MASONITE CORPORATION *AND SUBSIDIARIES WELFARE* BENEFIT PLAN

VISION BENEFITS

SUMMARY PLAN DESCRIPTION FOR

BENEFITS EFFECTIVE JANUARY 1, 2010

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INTRODUCTION

It's a pleasure to welcome you to the Plan and to offer you this vision program. Your vision is important to your health. Whether it's 20/20 or less than perfect vision, everyone should receive regular vision care. VSP's vision plan provides affordable and high-quality vision care.

This Summary Plan Description ("**SPD**") or "Booklet" summarizes the vision benefits under the Masonite Corporation and Subsidiaries Welfare Benefit Plan (the "**Plan**"). Please read this SPD carefully. This SPD is applicable to certain Eligible Employees of Masonite Corporation (the "**Company**") and their eligible Dependents, as further described in this booklet. This SPD is intended to provide you with an understanding of the benefits and administrative procedures of the vision benefit option. Vision benefits are governed solely by the terms of this SPD and the Plan document. The Plan's terms cannot be modified by any oral representation.

Vision benefits are not insured with the Vision Claims Administrator, ("**VSP**"), or any of its affiliates, but are merely administered by VSP. The Claims Administrator provides Participants with a national network of vision care Providers. The Plan does not warrant or guarantee the credentials, abilities, results, or quality of care of any vision care Provider inside or outside the claims administrator's Provider Network.

While the Claims Administrator may make coverage and payment decisions on behalf of the Plan, all decisions regarding diagnosis, treatment, care management, referrals or other vision care services or supplies should be made by you and the Provider.

Please read this SPD carefully. If you have any questions, the Claims Administrator's Customer Service Center will be happy to help you. The Customer Service Center may be reached at 1.800.877.7195, or go to the VSP Web site at www.vsp.com.

HELPFUL HINTS

- In order to receive the highest benefits, you must use VSP doctors. VSP doctors are optometrists and ophthalmologists who are able to perform exams and dispense eyewear. Retail chains are not part of the VSP network.

- Always verify that the doctor from whom you receive care is a VSP doctor, and that the services and supplies you receive are pre-authorized as "visually necessary" (as defined in this SPD). See "How to Use Your Benefits & Locate a VSP Doctor" in this Summary Plan Description for more details.

- If there is no VSP doctor available to you, this vision plan offers out-of-network coverage under a schedule of benefits. See "Use of Out-of-Network Providers" in this Summary Plan Description for more details.

- VSP doctors are required, by contract, to submit bills directly to VSP. They are also not allowed to "balance bill" you, unless you elect to obtain non-covered, non-visually necessary, or other unauthorized items. No balance billing means

that VSP doctors must accept the payment by VSP as payment in full for the services and/or supplies they provide to you, and you need to pay only for copays, coinsurance, and non-visually necessary or other unauthorized or non-covered items.

- If you use an out-of-network provider, you will receive an Explanation of Benefits or equivalent comprehensive receipt from VSP ("**EOB**"). The EOB contains important information on your claim and how it was processed. You should keep your EOB and any receipts from providers in case you ever have a question about a service that you received, or you are questioned by a provider about payments.

- Benefits for contact lenses are in lieu of ordinary lenses and frames. Your provider will help you determine which contact lenses are best for you based on your VSP coverage.

HIGHLIGHTS OF BENEFITS

	Signature Plan Provides Benefits for Exams, Lenses, Contacts (in lieu of lenses and a frame) ***Once Every Plan Year and Frames*** **Once Every Other Plan Year**

Description	***VSP Doctor Services and Supplies (in-network)***	***Out-of-Network Provider Services and Supplies***
Exam	Covered in full after $5 exam copay.	Reimbursed up to $50 (but not to exceed billed charges)
Lenses (Basic, Non-Coated)		
Single	Covered in full after $10 eyewear copay.	Reimbursed up to $50 (but not to exceed billed charges)
Lined Bifocal	Covered in full after $10 eyewear copay.	Reimbursed up to $75 (but not to exceed billed charges)
Lined Trifocal	Covered in full after $10 eyewear copay.	Reimbursed up to $100 (but not to exceed billed charges)
Lenticular	Covered in full after $10 eyewear copay.	Reimbursed up to $125 (but not to exceed billed charges)
Frames	Covered up to $120 allowance after $10 eyewear copay (which applies to frame & lenses). Plus a 20% discount off amounts over the allowance.	Reimbursed up to $70 (but not to exceed billed charges)

Contact Lenses (in lieu of lenses and frame)	Covered up to $105 (covered in full after $10 eyewear copay if visually necessary – see below).	Reimbursed up to $105 ($210 if visually necessary as outlined in this SPD). (but not to exceed billed charges)

BENEFIT COVERAGE

When You Visit a **VSP Doctor EYE**

EXAM

One eye exam every plan year by a VSP doctor – 100% coverage after $5.00 copay.

Covered Procedures: Eye exams administered by VSP doctors (optometrists or ophthalmologists) include all, or an appropriate combination of, the following items.

NOTE: There are certain eye exam procedures that are not covered. See Section 6 for Limitations and Exclusions.

Exam component	***What the doctor does***	***Why is it important?***
Case History	Determines patient's past visual and health history, general health, medications, and ocular (pertaining to the eye) symptoms	Aids in the final diagnosis
Visual System Evaluation: **external and internal exam, including direct and/or indirect ophthal-moscopy**	Views the retina, optic nerve head, and blood vessels using an ophthalmoscope Completes extraocular muscle assessment Analyzes pupillary reflexes Observes the cornea, lens, iris, conjunctiva, lids, and lashes with a microscope for magnified exam of the front of eye Performs a visual fields screening test Conducts tonometry test	Assesses the internal health of the eye and detects ocular disease if present Assesses neurologic integrity Assesses neurologic integrity Detects ocular diseases if present Evaluates ability of patient to see peripherally (outer area of the visual field) Aids in diagnosis or detection of glaucoma, measuring eye pressure

Exam component	*What the doctor does*	*Why is it important?*
Refractive Evaluation	Checks visual acuity to determine the clearness of eyesight at 20 feet and at 40 centimeters Subjective refraction Tests accommodation Conducts either keratometry or an objective refraction by retinoscopy or autorefractor	Aids in determining if a vision problem exists Determines the prescription that gives the patient the best perceived "clear" vision Determines the eyes' ability to focus Aids in determining a contact lens or eyeglass prescription
Other tests include	Binocular function	Determines the ability of the eyes to work together at both near and far distances
Diagnosis and treatment plan	Makes diagnosis and determines the treatment plan, including visual and eye health status. Doctors suspecting a systemic health condition will use the patient's established health plan referral guidelines for further evaluation and treatment	Identifies possible necessary visual treatments, such as corrective spectacles, contact lenses, and vision therapy. Also, ensures the earliest possible intervention for ocular and systemic disease

EYEWEAR

If prescribed, eyewear is covered at 100% after a $10 copay (for spectacle lenses and/or frame), to the extent they come under the allowances discussed below.

The frequency of these benefits is as follows:

ONCE PER PLAN YEAR

- Lenses – a pair of clear, single-vision, standard lined bifocal or lined trifocal lenses.
- Frame – up to a maximum allowance.

ONCE EVERY OTHER PLAN YEAR

- Contact Lenses – in lieu of lenses and a frame, up to a maximum allowance.

NOTE: There are certain items that are not covered. See Section 6 for Limitations and Exclusions.

Eyewear Benefit: A frame and pair of lenses (single-vision, standard lined bifocal or lined trifocal lenses) are covered under the eyewear benefit.

VSP fully covers a wide selection of frames available in the market today. The independent providers who participate with VSP must be able to dispense eyewear, including frames and lenses. Participants are able to choose from a wide selection of covered frames on display at each provider location, or to choose a frame that is not part of the covered selection.

When using VSP doctors, the participant is given an allowance towards the purchase of any frame of their choice. The participant is only responsible for the difference between the allowance for the frame, and the cost of the chosen frame, plus any applicable copayments. If the cost of the frame is equal to or less than the allowance, then the frame is covered in full. If you should choose a frame that is above your allowance, you will receive a 20% discount off the amount over the allowance.

Lenses that are not included in the list above, as well as special coatings and eyewear, require additional payment by you. However, these additional items are discounted for VSP members (see below). You also receive a 30% discount if you purchase a second, third or more pair(s) of prescription glasses or non-prescription glass on the same day as your exam, or 20% discount if you receive services within 12 months, from any VSP doctor.

Contact Lens Benefit: Contacts are provided in lieu of lenses and a frame. Standard contact lenses up to a cost of $105 are covered.

- The $105 contact lens allowance applies to both the contact lens exam (fitting and evaluation) and the contact lenses. The cost of the contact lens exam by the VSP doctor is discounted by 15% before the allowance is applied.

- Visually necessary contacts are covered in full after a $10 eyewear copay if obtained through a VSP doctor, but only if they are required for certain medical conditions that prevent the member from wearing eyeglasses.

Additional Items and Upgrades: The Plan is designed to cover your visual needs rather than cosmetic items. For example, if you select any of the following, there will be an additional charge. However, these charges are at VSP's preferred member pricing when you use a VSP doctor:

- Blended lenses

- Oversize lenses

- Coated lenses

- Progressive multi-focal lenses
- Photochromatic or transition lenses
- Cosmetic tinted lenses
- Certain limitations on low vision care
- High index lenses
- UV protected lenses

Value Added Discounts: If you choose contact lenses, but also wear prescription glasses, you'll benefit from valuable savings of 30% off the cost of non-covered pairs of prescription or non-prescription glasses (lenses and a frame) received from the same VSP doctor on the same day as the exam. You may also receive a 20% discount if you obtain services within 12 months from any VSP doctor.

Additionally you'll save 15% off the cost of your contact lens exam when you receive contact lens services from a VSP doctor. This discount does not apply to the price of your contact lenses.

Laser Vision Correction: VSP's Laser VisionCare program is available to VSP members. It is designed to provide you with a discount off laser surgery when obtained through VSP contracted doctors, surgeons and laser centers. This program includes the two most common laser vision correction procedures, laser-assisted in-situ keratomileusis (LASIK) and photorefractive keratectomy (PRK). Doctors for these procedures can be located by calling VSP Member Services or the VSP Web site. You can also ask your doctor if he or she is participating in the VSP Laser VisionCare program.

After surgery you may use your remaining frame allowance for non-prescription sun glasses provided by a VSP doctor.

Use of Out-of-Network Providers

If you decide to obtain a vision exam and/or eyewear from an out-of-network provider, you are responsible for paying the provider in full at the time of service. VSP will reimburse you up to the amount allowed under your plan's out-of-network provider reimbursement schedule (see below). Services obtained from out-of-network providers are subject to the same copayments and limitations as services obtained through VSP doctors. This reimbursement schedule does not guarantee full payment so you may have to pay an additional amount for services and eyewear.

After paying the out-of-network provider, you must send the following information to VSP within 6 months of the date of service:

- The provider's bill, including a detailed list of the services received.

- The patient's name, date of birth, address and telephone number.
- The relationship to the employee (self, spouse, child).
- The employee's name, Social Security Number (last 4 digits), address and phone number.
- The name of your employer, Masonite Corporation

Keep a copy of this information for your records and send the originals to:

VSP
P.O. Box 997105
Sacramento, CA 95899-7105

You will receive reimbursement up to these limits (after applicable copays):

$ 50.00	Exam
$ 50.00	Single Vision Lenses
$ 75.00	Bifocal Lenses
$ 100.00	Trifocal Lenses
$ 125.00	Lenticular Lenses
$ 70.00	Frame
$105.00	Elective Contact Lenses
$210.00	Visually necessary Contact Lenses (requires pre-approval)

HOW TO USE YOUR BENEFITS & LOCATE A VSP DOCTOR

Step 1: Identify a conveniently located VSP doctor

A. Access VSP Member Services at 1.800.877.7195 to request a VSP doctor listing. An Interactive Voice Response system is available after hours to verify eligibility, check plan coverage, confirm a doctor's participation in the VSP network, and request a list of doctors by mail. TDD for the hearing impaired is available at 1.800.428.4833.

B. Log on to www.vsp.com to find a conveniently located VSP doctor.

C. If you cannot find a doctor through these two methods, you may contact your Plan Administrator, who may be able to work with VSP to include your local out of network doctor in its network.

Step 2: Schedule an appointment

Once you have chosen a VSP doctor, call and schedule an appointment. Identify yourself as a VSP member and be prepared to provide the employee's Social Security number (last 4 digits). You will also be asked for your name, date of birth, and your employer).

The VSP doctor will contact VSP to verify your eligibility and plan coverage, and will also obtain authorization for services and eyewear. If you are not currently eligible for services, the VSP doctor is responsible for communicating this to you. VSP will pay the doctor directly for covered services and eyewear. No claim forms are required for services received from VSP doctors.

LIMITATIONS AND EXCLUSIONS

- Replacement of lost lenses and/or frames. Lost or broken lenses and frames will not be replaced except at the normal intervals when services are otherwise available.

- Medical or surgical treatment of eye conditions which require the services of a physician. If the exam discloses that such treatment is required, notification of this exclusion may be communicated to the participant for consideration. Under no circumstances will VSP be responsible for payment for any medical or surgical services.

- Services or eyewear for which the participant may be compensated under any Worker's Compensation Law or other similar employer's liability law, or services which the eligible participant, without cost, obtains from any federal, state, county, city, or other governmental organization.

- Orthoptics or vision training and any associated supplemental testing

- Plano lenses (non-prescription) with less than +/- .50 diopter power, except for sunglasses after laser surgery.

- Two pairs of glasses in lieu of bifocals

- Non-visually necessary services or supplies except as may be provided herein.

COORDINATION OF BENEFITS

Coordination of Benefits ("**COB**") is a limitation of the benefits provided under the plan, and is designed to avoid costly duplication of payment for vision services and related appliances.

COB is applied when a participant is covered under another plan(s) providing vision benefits, which contain a COB provision or are construed by law to contain a COB provision.

When a claim is submitted in accordance with the plan, and the claim involves another policy or plan, payment will be based on whether the plan is “primary” or “secondary” payor.

When the VSP plan is primary payor, benefits will be payable for covered services without regard to the participant’s coverage under other plans providing vision benefits.

When the VSP plan is secondary payor, the benefit payable will be up to the allowances under the plan (for examination, lenses and frames, etc.) that will be used to pay up to, but not more than, the patient’s eligible out-of-pocket expenses.

The following rules shall be used to determine the order in which benefits under the vision plan will be determined:

A. The benefits of a plan which covers the person as an employee, member, or insured, other than as a dependent, are determined before those of the policy or plan which covers the person as a dependent.

B. Except as stated in paragraph (C), when two or more policies or plans cover the same child as a dependent of different parents:

    1. The benefits of the policy or plan of the parent whose birthday, excluding the year of birth, falls earlier in a year are determined before those of the policy or plan of the parent whose birthday, excluding year of birth, falls later in the year; but,

    2. If both parents have the same birthday, the benefits of the plan which covered the parent for a longer period of time are determined before those of the plan which covered the parent for a shorter period of time.

However, if a plan subject to the rule based on the birthday of the parents as stated above coordinates with an out-of-state policy or plan which contains provisions under which the benefits of a plan which covers a person as a dependent of a male are determined before those of a policy or plan which covers the person as a dependent of a female and if, as a result, the plans do not agree on the order of benefits, the provisions of the other plan shall determine the order of benefits.

C. If two or more plans cover a dependent child of divorced or separated parents, benefits for the child are determined in this order:

    1. First, the plan of the parent with custody of the child;

    2. Second, the plan of the spouse of the parent with custody of the child; and

    3. Third, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the vision care expenses of the child, and if the entity obliged to pay

or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This does not apply with respect to any claim determination period or plan or policy year during which any benefits are actually paid or provided before that entity has the actual knowledge.

D. The benefits of a plan which covers a person as an employee who is neither laid off nor retired, or as that employee's dependent, are determined before those of a plan which covers that person as a laid off or retired employee or as that employee's dependent. If the other plan is not subject to this rule, and if, as a result, the policies or plans do not agree on the order of benefits, this paragraph shall not apply.

E. If none of the rules in paragraph (A), paragraph (B), paragraph (C), or paragraph (D) determine the order of benefits, the benefits of the plan which covered an employee, member, or participant for a longer period of time are determined before those of the plan which covered that person for the shorter period of time.

Coordination of benefits shall not be permitted against an indemnity-type policy, an excess insurance policy, a policy with coverage limited to specified Illnesses or accidents, or a Medicare supplement policy.

ELIGIBILITY

This SPD Booklet describes the vision benefits an eligible Employee may receive under the Plan upon completion of the Waiting Period (listed in the attached Schedule of Benefits) and payment of the employee contributions as established by the Company.

You are an eligible Employee if you are:

- included in the unit of Employees at the Employer’s Vandalia location covered by a collective bargaining agreement between employee representatives of a union and the Employer; (2) the bargaining agreement expressly provides that vision benefits are provided under the Plan for Employees in the bargaining unit who meet the eligibility requirements in this SPD, and (3) the applicable collective bargaining agreement is in effect at the time an Employee otherwise become eligible; or
- a Full-Time Employee of the Company, classified by the Company pursuant to its regular administrative practices as a non-union hourly employee or salaried common law employee on the U.S. payroll, and regularly scheduled to work at least 30 hours a week.

You are not eligible to participate in the Benefits listed in this SPD if the Company classifies you as an intern, seasonal, part-time, or temporary employee. If you are an independent contractor for the Company, you are not eligible for the vision coverage or any other benefit option offered by the Company, even if you are later determined to be an "employee" as a result of a judicial or administrative determination. If you are an Employee who is included in a unit of Employees covered by a collective bargaining agreement between employee representatives and the Company, you are only eligible for the vision benefits contained in this SPD if you work at the Employer's Vandalia location and meet the eligibility requirements listed above.

You may choose one of the coverage levels as outlined on the Group Insurance Enrollment & Change Form.

Eligible family members include;

- your spouse or domestic partner. A domestic partner is one person who meets the criteria in the Masonite Domestic Partnership Eligibility Guidelines. For a domestic partner to be considered eligible under our plans, the employee and his/her domestic partner must either (1) satisfy the eligibility requirements under this Policy and complete the attached Declaration of Domestic Partnership; or (2) submit appropriate evidence that the employee and his/he domestic partner are Registered Domestic Partners with any state or jurisdiction which permits Registered Domestic Partner status.

The following are Masonite guidelines in order to qualify for Domestic Partnership:

1. The Employee and his or her domestic partner are in a committed relationship which has existed for no less than (6) months prior to enrollment of the domestic partner in Masonite's health plans, and;

2. Both the Employee and the domestic partner have reached the age of 18, and;

3. Neither the Employee nor the domestic partner is legally married, their relationship is exclusive and both anticipate that this shall remain the case indefinitely, and;

4. The Employee and the domestic partner have maintained the same principle place of residence for at least (6) months and intend to do so indefinitely. Both are responsible to each other for the direction and financial management of their household and intend that this shall remain the case indefinitely, and;

5. Both the Employee and the domestic partner intend that all statements in the Domestic Partnership Affidavit will remain true indefinitely, and;

6. An employee can have only one domestic partner enrolled at any time and must solemnly affirm that he/she has no other domestic partners enrolled in Masonite benefit plans at this time.

7. After complying with all other conditions and providing the required documentation, a domestic partner may be enrolled in Masonite's health plans on the following dates only:

    - On the first day of the month following your date of hire;

    - On the first day of the month after you have satisfied domestic partner criteria; or

    - On the first day of the new plan year after adding the domestic partner during Open Enrollment

8. The cost of this coverage is considered imputed income to the Employee and is added as additional compensation on the Employee's paycheck and W-2 according to applicable federal law. The tax liability for this additional compensation will be borne by the employee.

9. Children of an enrolled domestic partner are eligible for Masonite's Medical, Dental and Life Insurance coverage under the same conditions as children of employees or their spouses.

10. Employees who sign a Domestic Partnership Affidavit are not eligible to claim reimbursement for the domestic partner or his/her eligible dependents through any flexible spending accounts.

11. Termination of coverage of a domestic partner will occur when:

    - any of the conditions on the Domestic Partnership Affidavit are no longer true

    - the employee and his or her domestic partner terminate their Registered Domestic Partner status under applicable state law; or

    - for any other disqualifying reason set forth in the applicable Masonite health plans.

12. Employees must notify Masonite Corporate Benefits when any condition in the Domestic Partnership Affidavit is no longer true or when Registered Domestic Partnership status is terminated for any reason.

13. Both the Employee and the domestic partner must each produce a copy of at least two of the following documents, which must accompany the Domestic Partnership Affidavit:

- Driver's license, vehicle registration, voter registration, utility bills, or other third party evidence of common address. Masonite does not require that individuals register as domestic partners, (even if such public registration is available in their community), in order to be eligible for benefits as described in these guidelines. However, individuals who have chosen to do so and can provide documentation of Registered Domestic Partner status in accordance with applicable law will also be eligible for benefits.

For the purposes of program eligibility, dependent child means;

- your children age 26 or younger
- a newborn child
- natural child
- legally adopted child
- stepchild who receives more than one-half of his/her support from the covered employee
- any other child for whom the covered employee has legal guardianship and who receives more than one-half of his/her support from the covered employee; and
- any child that is ordered covered through a National Medical Support Notice or Qualified Medical Child Support Order.

ENROLLMENT

Initial Enrollment Period

As a newly eligible full-time Employee, you may participate in the Plan as long as you complete your enrollment within 31 days of your date of eligibility by following the procedures outlined in your enrollment materials.

If you have any questions during this process, call the HR/Benefits line at 1.866.554.4054.

You will need to enroll your eligible Dependents during your Initial Enrollment. Your participation will start on the date in your enrollment materials as long as you complete enrollment within 30 days of your date of hire. The benefit choices you make during your Initial Enrollment Period will remain in effect for the remainder of the Plan Year, unless you experience a Qualified Change in Status Event and you make new benefit elections.

If you do not enroll yourself (and your eligible Dependents) during your Initial Enrollment Period, you will not receive coverage under the Plan and you may not enroll until the next Open Enrollment Period, or until you experience a Qualified Change in Status

Event.

Open Enrollment Period

Enrollment for vision benefits is a two year election, the Company establishes an Open Enrollment Period, which is usually in November. During the Open Enrollment Period, you can enroll for the first time or make new benefit choices for the upcoming Plan Year by completing on-line enrollment. You may also enroll eligible Dependents during the Open Enrollment Period. If you enroll during the Open Enrollment Period, your participation will start on the first day of the Plan year following the Open Enrollment Period. If you do not enroll or make new benefit choices during the Open Enrollment Period, then you must wait to enroll or to change your benefit choices until the next Open Enrollment Period, or until you experience a Qualified Change in Status Event.

If you previously enrolled in the Plan but you do not enroll or make new benefit choices during the Open Enrollment Period, then your choices for the previous Plan Year will continue during the upcoming Plan Year. If you are eligible to participate in the Plan, and the Open Enrollment Period falls during a time when you are on a FMLA leave of absence, the Company will contact you so that you may make your benefit elections during the Open Enrollment Period.

All covered Employees and their covered Dependents will need to provide proof of eligible dependent status upon request by the Company or its designee. The Company may request proof of dependent status at any time and for any reason. If you fail to timely comply with a dependent audit or do not submit this proof by the date specified, your Dependent coverage will be terminated. Even if you have previously submitted proof of dependent status, you are still required to provide a copy upon request.

If the Company determines that you have enrolled an ineligible person or you fail to notify the Company of a change in your Dependent's eligibility status you will be:

- responsible for any claims, expenses, reimbursements or other costs paid during a period of ineligibility; and
- subject to disciplinary action up to and including termination of employment.

For purposes of the HIPAA Privacy and Security Rules, determining the Employee's eligibility for the Plan or enrolling Employees in the Plan is an enrollment function performed by the Company. Employee and Dependent eligibility and enrollment information is the Company's information and not the Plan's information while it is held and transmitted by the Company.

Masonite has a benefits portal which is accessed through MployeeCentral that allows you to complete your Group Insurance Enrollment Online and view the benefits available to you. Enrollment is done exclusively through this website. Please refer to the MployeeCentral Pamphlet for guidance.

Qualified Medical Child Support Orders

The Plan Administrator will comply with the terms of a Qualified Medical Child Support Order ("**QMCSO**") to the extent that the QMCSO does not require the Plan to provide coverage it does not otherwise provide. A medical child support order is any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or an administrative process established under state law which has the force and effect of law or a judgment from a state court directing a plan administrator to cover a child under a company's group health plan. A QMCSO also may include a National Medical Support Notice.

Federal law requires that a medical child support order must meet certain form and content requirements in order to be a QMCSO. When an order is received, each affected Participant and each child covered by the order will be notified of the implementation procedure to determine if the order is valid. If you have any questions or would like to receive a copy of the written procedures for determining whether a medical child support order is a QMCSO, you may request a copy of the procedures from your local Human Resources Department at any time and without charge.

Generally, if the Company or the Plan Administrator receives an order that is a QMCSO, coverage for the eligible Dependent child that is the subject of the QMCSO will become effective on the date specified in the QMCSO, or at a later date as specified in the Plan's QMCSO procedures. The Plan Administrator has full discretionary authority to determine whether a medical child support order is "qualified" within the meaning of ERISA Section 609(a)(2)(A), and reserves the right, waivable at its discretion, to seek clarification with respect to the order from the court or administrative agency that issued the order, up to and including the right to seek a hearing before the court or agency.

Qualified Change in Status Events**

You cannot change your elections during the Plan Year unless you experience a Qualified Change in Status Event ("**Change Event**"), and the change you want to make is consistent with the Change Event.

***You must provide proof of a change in an eligible Dependent's status to your Local Human Resources Department.*

Any of the following events are Change Events:

- You or your eligible Dependent become eligible or ineligible for coverage on account of a change in:
  - legal marital status (for example: Marriage, divorce, legal separation, annulment);
  - number of Dependents (for example: birth, death, adoption, placement for adoption);
  - your employment status or your Dependent's employment status (for example, termination or commencement of employment, taking or returning from an unpaid

leave of absence - including those protected under the FMLA, changing from part-time to full-time, or union to non-union, or *vice versa*);
  - residence or work site; or
  - a Dependent's status (for example, a Dependent becomes eligible or ineligible for benefits under the Plan).
- A change in coverage due to an election made by your Spouse or Dependent under the Spouse's or Dependent's employer's benefit plan if:
  - the other employer plan has a different open enrollment period that relates to a period that is different from the Plan Year for this Plan (for example, your Spouse's open enrollment period is in January and your Spouse changes coverage); or
  - the other employer plan allows an election change for a Change Event as provided under the cafeteria plan regulations.
- A change in the availability of benefit options or coverage (addition or removal) under the Plan's vision benefit options or under your Spouse's or Dependent's employer's benefit plan.
- A significant increase or decrease in the cost of coverage during the Plan Year.
- A judgment, decree, or order, resulting from a divorce, legal separation, annulment, or change in legal guardianship that is a Qualified Medical Child Support Order, is entered by a court of competent jurisdiction that requires vision coverage for your child under this Plan or requires another individual to provide coverage to the child.

Consistency Rule

Your election changes must be consistent with the Change Event that affects your coverage under the Plan's vision benefits. For example:

- if one of your eligible Dependents no longer qualifies as an eligible Dependent, you could cancel coverage for that Dependent, but you could not cancel coverage for your other eligible Dependents; or
- if you have single coverage and you marry, you may elect family coverage.

Some of the Change Events may allow you the option of either adding or removing coverage. For example, your Spouse changing an election under his or her employer's plan may allow you to elect or revoke coverage under this Plan, so long as your choice is consistent with your Spouse's election. The Permissible Election Changes chart at the end of this section includes examples of election changes that are consistent with Change Events. If you are not sure the election change you would like to make is consistent with the Change Event, you should contact your Local Human Resources Department.

Procedures for Changing Elections Mid-Year

If you want to change your election because of one of these Change Events, you may do so by notifying your Local Human Resources Department and identifying the event that resulted in the change and specifying how you want your elections changed. You

must also submit proof of the Change Event on or before the date that is 31 days after the date of the Change Event along with any required proof.

If the Change Event is the birth or adoption of a dependent child, the change in coverage and your payroll contributions will take effect as of the date of the Change Event if you file your change on or before the date that is 31 days after the date of the Change Event. For all other Change Events (with the exception of a dependent who no longer qualifies as an eligible Dependent), the change in coverage and your contributions will take effect on the first of the month following the date you submit your request to change your elections, provided that you submit the request on or before the date that is 31 days after the Change Event. You will be required to show proof of the Change Event. If you file a request more than 31 days after the Change Event, no changes will be made to your elections, coverage or contributions, but you may make the necessary change during the next open enrollment period.

For a dependent who no longer qualifies as an eligible Dependent, the change in coverage will automatically take effect as of the date the Dependent is no longer eligible for the Plan, regardless of whether you request an election change within the 31-day period. The Plan will return any contributions made on behalf of the ineligible individual and has the right to recover from you any payments the Plan makes on behalf of an individual who is no longer an eligible Dependent.

PERMISSIBLE ELECTION CHANGES

Change Event	Permissible Election Change
Marriage	Add or remove Dependent coverage, cancel Employee coverage
Divorce/Legal Separation	Cancel Spouse or Employee coverage or coverage for a child that ceases to qualify as an Eligible Dependent
Birth, Adoption or Placement for Adoption	Add Dependent
Death of Spouse	Cancel Spouse coverage
Death of Child	Cancel Child coverage
Change of Employment Status *(e.g.,* part-time to full-time)	Enroll

Dependent Gains employment	Cancel coverage for Employee and/or Dependent(s)

PERMISSIBLE ELECTION CHANGES

Change Event	Permissible Election Change
Dependent Loses Employment	Enroll Employee and/or Dependent(s)
Dependent Gains Dependent Status	Enroll Dependent(s)
Dependent Loses Dependent Status	Cancel coverage for affected Dependent only
Open Enrollment Under Spouse's Plan	Enroll or cancel coverage

Participation During a Leave of Absence

Under the Family and Medical Leave Act of 1993, as amended ("**FMLA**"), you may qualify for up to a 12 week leave of absence or a 26 week service-member caregiver leave of absence. With Company approval, you may take an FMLA leave of absence and remain a participant in the Plan during this time. You will be entitled to the same benefits that you were receiving immediately before the start of your FMLA leave.

If Your FMLA Leave of Absence is Paid

If you are taking a paid leave of absence, the Company will continue to make payroll deductions to collect your contributions for the vision benefit coverage for which you are currently required to make contributions.

If Your FMLA Leave of Absence is Unpaid

If you are taking an unpaid leave of absence, and you are currently required to contribute a certain amount for your coverage, you must make arrangements with your Local Human Resources Department to pay for the coverage you wish to maintain during the course of your leave. You can pay for your required contributions:

- ***In advance of your leave***. You may pay for the coverage you wish to maintain in advance of your leave with after-tax payments by sending a check or money order to your Local Human Resources Department.

- ***During your leave by sending a check or money order to your Corporate Human Resources Department according to your regular payroll schedule***. Each payment must be received by your Corporate Human Resources

Department by the first business day of each month. If you do not make the required contributions, your benefits will continue, but you will be required to reimburse the Company for any past-due amounts by increasing your pre-tax or after-tax contributions when you return from your leave.

- ***When you return from your leave by increasing your pre-tax or after-tax contributions***. For pre-tax contributions, the Company may only collect pre-tax contributions that you owe for the current Plan Year within the same Plan Year. If you still owe contributions, the Company will collect any remaining contributions in the next Plan Year on an after-tax basis.

If the Company advances money by making contributions for you, in whole or in part, it can recoup the amounts advanced through payroll deductions upon your return to employment following your leave. If you do not return from an FMLA qualified leave due to the continuation of a serious health condition, serious illness or injury of a covered service-member, or circumstances beyond your control, the Company will not require reimbursement. If you do not return from an FMLA qualified leave for any other reason, you may be required to reimburse the Company for the entire cost to the Company for providing the medical benefits during your leave the Company continued to provide to you during your leave. If you are required to reimburse the Company, you must do so within 30 days from the date you should have returned from your FMLA leave.

You should refer to the Company's Leave of Absence Policy and consult with your Local Human Resources Department before taking any leave.

END OF COVERAGE/COBRA

When coverage ends, the Plan will not provide benefits for any services or supplies furnished or rendered after the period for which employee contributions have been paid.

End of Participation in the Plan

Your participation in the Plan will end under the following conditions:

- You terminate employment or you change to ineligible status. Your participation ends on the end of the month in which you terminate employment or change to ineligible status.
- You do not return to employment after your Company approved FMLA leave of absence. Your participation ends on the date you should have returned to employment with the Company.
- You are laid off by the Company. Your participation ends on the end of the month in which your layoff occurs.
- You cancel your participation during an Open Enrollment Period. Your participation will end on the last day of the current Plan Year.

- You cancel your coverage under after a Change Event. Your participation will end as of the last day of the month in which the Change Event occurs so long as you submit your request to change your elections to the Company within 31 days of the date of the Change Event.
- You stop making contributions. Your participation will end on the last date for which you have made contributions.
- The Company terminates the Plan or medical benefits. Your participation will end on the effective date of the termination.

An Eligible Dependent's coverage will end as follows:

- on the date your coverage under the Plan terminates;
- on the date the dependent is no longer an eligible Dependent (even if the Plan learns of the ineligibility at a later date);
- on the date you cancel coverage due to a Change Event and the timely notice of it; or
- for an eligible Dependent who is covered by the Plan under the terms of a Qualified Medical Child Support Order, on the date coverage ends according to the terms of the Qualified Medical Child Support Order.

COBRA Continuation Coverage

Under certain circumstances you or your eligible Spouse and Dependent children (covered by the Plan ("**Covered Dependents**") have the right, under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("**COBRA**"), to continue coverage under the Plan ("**COBRA Continuation Coverage**" or "**Continuation Coverage**"). COBRA Continuation Coverage is available to you and to Covered Dependents when you or they would otherwise lose group health coverage. This section generally explains COBRA Continuation Coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

COBRA Continuation Coverage for the Plan is administered by OneSourceVirtual. 5601 North MacArthur Blvd., Suite #100, Irving, TX 75038 **("COBRA Administrator).**

Qualifying Events

COBRA Continuation Coverage is available if you are enrolled in the Plan and you and your Covered Dependent's enrollment would otherwise end on account of a "**Qualifying Event**." COBRA Continuation Coverage is offered to each person who is a Qualified Beneficiary. A "**Qualified Beneficiary**" is someone who will lose coverage under the Plan because of a Qualifying Event.

You will become a Qualified Beneficiary if you will lose your coverage under the Plan because either of the following Qualifying Events occurs:

- your hours of work are reduced; or
- your employment ends for any reason other than your gross misconduct.

Your Covered Dependent Spouse and/or Covered Dependent child will become a Qualified Beneficiary if coverage under the Plan will be lost because any of the following Qualifying Events occur:

- your death;
- your hours of employment are reduced;
- your employment ends for any reason other than your gross misconduct;
- You become entitled to Medicare benefits (under Part A, Part B, or both);
- You become divorced or legally separated from your Spouse; or
- your child stops being eligible for coverage under the Plan as an eligible Dependent. (For this Qualifying Event, only the Covered Dependent Child becomes a Qualified Beneficiary.)

The Plan offers COBRA Continuation Coverage to Qualified Beneficiaries only after the COBRA Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the termination of your employment or a reduction of your hours of employment, your death, or your entitlement to Medicare benefits (under Part A, Part B, or both), the Company will notify the COBRA Administrator of the Qualifying Event within 30 days of any of these events.

For the other Qualifying Events (divorce or legal separation or a dependent child's loss of eligibility for coverage as an eligible Dependent), you or a Qualified Beneficiary with respect to the Qualifying Event, or a person acting on your or his or her behalf, must notify the COBRA Administrator in writing **within 30 days after the latest of:**

- the date of the Qualifying Event; or
- the date on which you or a Covered Dependent loses (or would lose) coverage under the Plan.

If you, a Qualified Beneficiary, or a person acting on your or his or her behalf, do not provide the notice to the COBRA Administrator within the time limit explained above, coverage under the Plan cannot be continued.

After a Qualifying Event has occurred, you and your Covered Dependents will be notified by the COBRA Administrator about your/their right to COBRA Continuation Coverage. The COBRA Administrator, on behalf of the Plan Administrator, has 44 days from the later of the date of the loss of coverage or the Qualifying Event, to provide you and your family members with a notice of your right to elect COBRA continuation coverage ("**COBRA Election Notice**").

Electing COBRA Continuation Coverage

If it is determined that you and each of your Covered Dependents qualify for COBRA Continuation Coverage, each of you may individually decide whether or not to continue coverage. You and each of your Covered Dependents will have the right to elect the

same coverage under the Plan, in which you were enrolled immediately before the Qualifying Event. Both you and your Spouse may elect COBRA Continuation Coverage, or only one of you may choose it. Spouses may elect coverage for each other and parents may elect to Continue Coverage on behalf of their Covered Dependent children. **If you or a Covered Dependent wants to elect Continuation Coverage, you must do so within 60 days of the date the notice of your right to elect COBRA Continuation Coverage was sent by the COBRA Administrator.**

As long as you elected and you are covered by the COBRA Continuation Coverage during the Plan's Open Enrollment Period, you may make changes to your coverage during the Open Enrollment Period, including adding new coverage or changing your options.

Premium Payments

COBRA Continuation Coverage is at your expense or your Covered Dependent's expense. The monthly cost of COBRA Continuation Coverage will be included in the notice sent to you. The amount you must pay for COBRA Continuation Coverage will not exceed 102 percent of the cost for this coverage to the Plan (including both the Company's and your contributions) for a similarly situated Participant or beneficiary who is not receiving COBRA Continuation Coverage (or, in the case of an extension of COBRA Continuation Coverage due to a disability, 150 percent of that cost). You will have to pay COBRA premiums on an after-tax basis.

For coverage to continue, the first premium must be received by the date stated in the notice sent to you. Normally, this date will be 45 days after COBRA Continuation Coverage is elected. Premiums for every following month of Continuation Coverage must be paid monthly on or before the premium due date stated in the notice sent to you. There is a 30-day grace period for these monthly premiums. If they are not paid within 30 days after their due date, COBRA Continuation Coverage will end as of the first day of that period of coverage and cannot be reinstated. If a partial premium payment is made that falls short of the current amount due by a minimal amount, you will be notified, and, if the shortfall is not paid within 30 days of the date the notice is received, COBRA Continuation Coverage will end as of the first day of that monthly period of coverage.

Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than its due date but during its grace period, your coverage under that Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

Duration of Coverage

COBRA Continuation Coverage for you and/or your Covered Dependents who elect coverage and are Qualified Beneficiaries will start on the date of the Qualifying Event and may continue until the earliest of the following:

- 18 months should your employment end and/or your hours be reduced.
- 29 months should a Qualified Beneficiary qualify for a disability extension (refer to "Disabled Individuals," below).
- For your Covered Dependents who are Qualified Beneficiaries, 36 months in the event of your divorce or legal separation, your death, or your becoming entitled to Medicare benefits (under Part A or Part B, or both), or your Covered Dependent child's loss of dependency status.
- The date on which a premium payment was due but not paid.
- The date after the Qualified Beneficiary first becomes covered under another employer's Group Health Plan, provided the Qualified Beneficiary becomes covered after his or her election of COBRA Continuation Coverage.
- The date the Qualified Beneficiary first becomes entitled to (enrolled in) Medicare benefits (under Part A or Part B, or both); provided the Qualified Beneficiary becomes enrolled in Medicare benefits after his or her election of COBRA Continuation Coverage.
- The date the Company terminates all of its group medical plans.

If a Qualified Beneficiary's COBRA Continuation Coverage is terminated for any reason before the maximum period of coverage to which you were entitled, the Qualified Beneficiary will be notified of that fact and provided with an explanation of why Continuation Coverage was terminated.

Newborns and Adopted Children

If you or your Spouse elect COBRA Continuation Coverage, any child born to or adopted by you and your Spouse during the period of Continuation Coverage will also be a Qualified Beneficiary, and be entitled to Continuation Coverage for the maximum period of coverage available to any family member who is also a Qualified Beneficiary, as long as you notify the COBRA Administrator within 60 days of the birth or adoption.

Second Qualifying Event

If COBRA Continuation Coverage was elected by a Covered Dependent because your employment ended or your hours were reduced (including COBRA Continuation Coverage during a disability extension period) and if, during the period of Continuation Coverage, another Qualifying Event occurs, the maximum period of Continuation Coverage for the Covered Dependent is extended, upon proper notice to the COBRA Administrator, for up to an additional 18 months (that means, to a maximum of 36 months from the date your employment ended or your hours were reduced). This extension may be available to your Covered Dependents receiving COBRA Continuation Coverage in the event of your death or divorce, or if your dependent child

stops being an eligible Dependent under the Plan, but only if the event would have caused the Covered Dependent to lose coverage under the Plan had the first qualifying event not occurred. Continuation Coverage will still end for any of the other reasons listed above, such as failure to pay premiums when due, etc.

you or the Covered Dependent, or a person acting on your or his or her behalf, must notify the COBRA Administrator **in writing within 60 days after the latest of:**

- the date of the second Qualifying Event; or
- the date on which the Covered Dependent would lose coverage under the Plan as a result of the second Qualifying Event.

It is your obligation to notify your local Benefits Administrator within 60 days after the occurrence of a Qualifying Event. You must include your name, the names of your covered Dependents, the evidence of the Qualifying Event, and the date of the Qualifying Event in your written notice.

Covered Dependents of Medicare-Eligible Employees

If you become entitled to Medicare (Part A or B) while you are still employed by the Company (but no more than 18 months before the Qualifying Event) and you then lose your health coverage because of a Qualifying Event that is a termination or reduction in your hours of employment, then your Covered Dependents may elect COBRA Continuation Coverage for the balance of the 36-month period starting when you became entitled to Medicare. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his covered Spouse and Covered Dependent children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

you or your Covered Dependents, or a person acting on your or their behalf must provide notice of your entitlement to Medicare benefits (under Part A, Part B or both) within the time limit and in the manner described above for second Qualifying Events.

Disabled Individuals

When the Qualifying Event for COBRA Continuation Coverage is your termination of employment or the reduction in your hours of employment, the 18-month period of COBRA Continuation Coverage is extended by an additional 11 months (to a total of 29 months) if these two conditions are met:

- The Social Security Administration determines that a Qualified Beneficiary (you or a Covered Dependent) is disabled, and that the date the Qualified Beneficiary's disability began was either:
  - within the first 60 days of Continuation Coverage (in the case of a child born to or placed for adoption with you and your Spouse, the 60-day period is measured from the date of birth or placement for adoption); or

  - before the Qualifying Event and the Social Security Administration considers that the Qualifying Beneficiary remains disabled as of the date of the Qualifying Event.
- You or a Covered Dependent, or a person acting on your or his or her behalf, provide written notice to the COBRA Administrator of the Social Security Administration's disability determination before the end of the original 18-month period of Continuation Coverage and **within 60 days** after the latest of:
  - the date of the disability determination by the Social Security Administration;
  - the date on which the Qualifying Event occurred; or
  - the date on which you or a Covered Dependent loses (or would lose) coverage under the Plan as a result of the Qualifying Event.

The 11-month disability extension of COBRA Continuation Coverage will end on the first day of the month following the date the Qualified Beneficiary is determined not to be disabled. Continuation Coverage due to the initial employment-related Qualifying Event, or any subsequent Qualifying Event, may still be available if the maximum period for such Continuation Coverage has not expired as of the date a determination of "no longer disabled" is made. The cost of Continuation Coverage for the 11-month disability extension will, however, increase after the 18th month of Continuation Coverage, unless coverage would continue in any event on account of a second Qualifying Event. The increase, if any, will not exceed 150 percent of the cost to the Plan, including both Company and employee contributions, for coverage of a similarly situated Participant (as applicable) who is not receiving Continuation Coverage.

Form and Manner of Notice to the Company COBRA Administrator

Any notice to the Company or to the COBRA Administrator will need to be in writing and must include:

- the name of the employee or former employee who is or was a Plan participant;
- a description of the Qualifying Event (and second Qualifying Event, if any);
- the date of the Qualifying Event (and second Qualifying Event, if any); and
- the name(s), address(es) and Social Security number(s) of the employee and/or Covered Dependents involved in the Qualifying Event; and
- for a disabled individual, a copy of the Social Security Administration disability determination and the date of the determination.

The timely provision of the notice by one individual will satisfy the notice requirement on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Carryover of Benefit Maximums

If a qualified beneficiary under COBRA elects continuation of vision coverage under the Plan, expenses already credited to the Plan's applicable full payment feature for the calendar year will be carried forward into the continuation coverage elected for that same calendar year. Similarly, amounts applied toward any maximum payments under

the Plan will also be carried forward into the continuation coverage. Coverage will not be continued for any benefits for which Plan maximums have been reached.

Trade Act

If you should lose your job, and, as a consequence, are eligible for trade adjustment assistance under the Trade Act of 2002, or if you are at least age 55 and receiving a pension benefit from the Pension Benefit Guaranty Corporation, you may be eligible to take a tax credit or get advance payment of up to 65 percent (or 80 percent before January 1, 2011) of your COBRA Continuation Coverage premiums. In certain circumstances, you may also be eligible for a second 60-day COBRA Continuation Coverage election period. In accordance with the American Recovery and Reinvestment Act of 2009, you may also be eligible for a temporary extension of the applicable maximum period of COBRA Continuation Coverage. If you have questions about these Trade Act provisions, you may contact the Health Coverage Tax Credit Customer Contact Center toll-free at 866.628.4282 or 866.626.4282 (TTD/TTY). More information about the Trade Act is also available at www.doleta.gov/tradeact.

Questions About COBRA Continuation Coverage

If you have questions about COBRA Continuation Coverage, you may contact the COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**"), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration in your area or visit its website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District Employee Benefits Security Administration offices are available through its website.

Keep the Plan Informed of Address Changes

In order to protect your family's rights, you should keep the COBRA Administrator informed of any changes in the addresses of family members. You should also keep copies, for your records, of any notices you send to the COBRA Administrator.

MILITARY LEAVE CONTINUATION COVERAGE

If you take a military leave of absence in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("**USERRA**"), you have the right to elect up to 24 months of continuation coverage for you and your Covered Dependents under the Plan. Your Eligible Dependents who are participants in the Plan immediately before the date of your qualified military leave of absence are eligible to elect continuation coverage under USERRA as well.

If you do not wish to receive some or all of the coverage during your military leave that you were receiving just prior to your leave, you must inform your Local Human Resources Department before the start of your leave. Benefits under the Plan will terminate on the last day of the month you start your leave of absence.

If you elect continuation coverage under USERRA, you or your Covered Dependent are responsible for the entire cost of this coverage after a period of time. If you are absent from work due to active duty for a period not longer than 12 weeks, the cost of the coverage will be the amount charged to active employees for the same coverage. For leaves that extend beyond 12 weeks the cost may be up to 102 percent of the total cost of coverage under this Plan which includes your share of the cost of coverage and any portion previously paid by the Company, as well as a two percent administrative fee. In some cases, you and/or your family members can apply for continuing coverage, as described in the COBRA continuation coverage information described below.

CLAIMS FILING

VSP Doctor

Once you have chosen a VSP doctor, call and schedule an appointment. You must give the doctor the patient's name, date of birth, the employee's Social Security number and employer. Be sure that you and your covered family members identify themselves as having VSP coverage. The doctor will file the claim form for you. No claim forms are required.

Out-of-Network Provider

If you decide to obtain a vision exam and/or eyewear from an out-of-network provider, you are responsible for paying the provider in full at the time of service, and then apply to VSP for reimbursement within six months. Write the employee's name, address, phone number and Social Security number; and the patient's name, date of birth, address, phone number and relationship to you, on your itemized, paid receipt and mail to the address below. Make sure to write the name of your employer as well.

VSP
P.O. Box 997105
Sacramento, CA 95899-7105

Please see Section 4 for reimbursement limits for out-of-network providers, and Section 10 for your rights under ERISA including those relative to claims procedures.

Claim Procedures

ERISA also requires VSP and the Plan to abide by certain time-frames and other requirements with respect to claims filed by participants or their providers. Information regarding claim submission may be obtained from the Plan Administrator. A claim or an appeal of a denied claim is not deemed "filed" or "received" for purposes of these claims procedures until it is filed in accordance with this SPD and is received by the Claims Administrator, as applicable. Neither You, your beneficiary, or any Participant may bring any legal action to recover benefits under the Plan, to enforce or clarify your rights under the Plan under Section 502 or Section 510 of ERISA, or under any other provision of law, whether or not statutory, until the claim and appeal procedures in this SPD have been exhausted in their entirety.

VSP will process the claim and make payment or issue a denial notice.

Claim Denial Appeals

If, under the terms of this Plan, a claim is denied in whole or in part, a request may be submitted to VSP by the participant or the participant's authorized representative for a full review of the denial. A participant may designate any person, including their provider, as their authorized representative. References in this section to "participant" include Participant's authorized representative, where applicable.

Initial Appeal

The request for initial appeal must be made within one hundred eighty (180) days following denial of a claim and should contain sufficient information to identify the participant for whom the claim was denied including the participant's name, the participant's Member Identification Number, the participant's name and date of birth, the provider of services and the claim number. The participant may review, during normal working hours, any documents held by VSP pertinent to the denial. The participant may also submit written comments or supporting documentation concerning the claim to assist in VSP's review. VSP's response to the initial appeal, including specific reasons for the decision, shall be provided and communicated to the participant as follows:

Prior authorization for Visually Necessary or Appropriate services:

within thirty (30) calendar days after receipt of a request for an appeal from the Participant;

Denied claims for services rendered:

within thirty (30) calendar days after receipt of a request for an appeal from the Participant.

Second Level Appeal

If the Participant disagrees with the response to the initial appeal of the claim, the Participant has a right to a second level appeal. Within sixty (60) calendar days after receipt of VSP's response to the initial appeal, the Participant may submit a second appeal to VSP along with any pertinent documentation. VSP shall communicate its final determination to the Participant in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

Other Remedies

The Plan may, in its sole discretion, reverse VSP's denial of a claim after all appeals have been concluded. When Participant has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Group or VSP will advise participants to contact the U. S. Department of Labor for details. Additionally, under the provisions of ERISA Section 502(a)(I)(B), a participant has the right to bring a civil action when all available levels of

review of denied claims, including the appeal process, have been completed, the claims were not approved in whole or in part, and participant disagrees with the outcome.

Time of Action

Participants may not bring any legal action for payment of benefits prior to the participant using up his or her grievance or claim appeal rights, as applicable.

Legal Actions

You may not file for legal action on your vision claim until you first complete the claim review/appeal process as explained above, including an appeal to an external review organization.

You must follow the claim and review procedure carefully and completely and you must file your claim before the deadlines explained below. If you do not do so, you will give up important legal rights.

You must submit your claim for benefits within one (1) year after the earlier of the date on which you were denied benefits or received benefits at a different level than you believed the Plan provides. After you file your claim, you must complete the entire claim and review process before you can sue over your claim. It is important that you include all the facts and arguments that you want considered during the claim and review process.

Any legal action to receive benefits must be filed the earlier of:

- Six months from the date a determination is made under the Plan or should have been made in accordance with the Plan's claims review procedures, or
- One year from the date the service or treatment was provided or the date the claim arose, whichever is earlier.

your failure to file suit within this time limit results in the loss/waiver of your right to file suit.

Limitations of damages

In the event a covered person or his representative sues the Plan, or the Company, or any of its directors, officers, or employees acting in his or her capacity as director, officer, or employee, for a determination of what coverage and/or benefits, if any, exist under the Plan, the damages shall be limited to the amount of the covered person's claim for benefits as set forth in ERISA. The damages shall not exceed the amount of the claim, if any, properly paid in accordance with the terms of the Plan as of the time the lawsuit is filed.

Laws governing the Plan

This Plan is governed by federal laws regulating employer welfare plans.

Plan's and Claims Administrator's relationship to providers

The choice of a health care Provider is solely the covered person's. Providers are neither employees nor agents of the Plan or the Claims Administrator. The Claims Administrator contracts with an appropriate Provider to provide services to you. The Claims Administrator's inclusion or exclusion of a Provider in any network is not an indication of the Provider's quality or skill. The Plan, the Company and the Claims Administrator does not make any guarantees about the services of any Providers.

The Plan, the Company, and the Claims Administrator does not furnish covered services but only make payment for them when received by covered persons.

The Plan, the Company and the Claims Administrator are not liable for any act or omission of any Provider, nor responsible for a Provider's failure or refusal to render covered services to a covered person.

DEFINITIONS

Bifocal lenses - Visible line across lens.

Explanation of Benefits – Provides details regarding how your insurance company processed the claims. The Explanation of Benefits tells you what portion of a claim was paid to VSP and what portion of the payment, if any, you are responsible for.

Lenticular - Pertaining to or shaped like a lens, pertaining to the lens of the eye ,and pertaining to the lenticular nucleus.

Bifocal lenses - Visible line across lens

Lined Tri-focals - Provide three prescription powers: a distance power, a mid-range power, and a near power. The distance power helps you see things at a distance, the mid-range power helps you see things at intermediate distances, and the near power corrects your vision close up.

Provider - Any ophthalmologist, optometrist, optician or optical supplier as defined herein:

1. Ophthalmologist - a doctor of medicine (m.d.) specializing in ophthalmology and licensed to practice medicine in the state where covered services are provided.

2. Optometrist - a doctor of optometry (o.d.) licensed to provide vision care in the state where services are provided.

3. Optician/optical supplier - one who is a specialist in filling prescriptions for corrective lenses for eyeglasses and contact lenses, and is licensed in the state where covered services are provided.

Waiting period - a period of days the member is not entitled to benefits for specified services, beginning on the individual member's effective date under this plan

SUBROGATION

In the event any payment for benefits of past or future claims provided to a Participant under the Plan is made to or on behalf of a Participant, on account of a condition resulting from the negligence or fault of or from a third party, Plan Sponsor, to the extent of such payment, shall be subrogated to all causes of action and all rights of recovery such Participant has against any person or organization. Such subrogation rights shall extend and apply to any settlement of a claim, irrespective of whether litigation has been initiated. The Participant shall execute and deliver such instruments and papers pertaining to such settlement of claims, settlement negotiations, or litigation as may be requested by the Plan Administer or Claims Administrator, and shall do whatever is necessary to enable the Plan Sponsor or Claims Administrator to exercise its rights of subrogation and shall do nothing to prejudice such rights. Further, the Participant or the Participant's legal representative shall promptly notify Plan Sponsor of any settlement negotiations prior to entering into any settlement agreement, shall disclose to Plan Sponsor any amount recovered from any person or organization that may be liable for bodily injuries and shall not make any settlements without our written consent. No waiver, release of liability, or other documents executed by you without such notice to Plan Sponsor and cooperation by You, if requested, shall be binding upon Plan Sponsor.

The Plan shall have the right of first reimbursement out of any recovery the Participant may obtain in any recovery from a third party, even if the Participant is not made whole. The "make whole" doctrine shall not apply to any subrogation rights under the Plan.

Any such right of subrogation or reimbursement provided to Plan Sponsor under the Plan shall not apply or shall be limited to the extent that the Florida Statutes for the courts of Florida eliminate or restrict such rights.

ERISA INFORMATION

Name and Type of Plan

The name of the Plan is the Masonite Corporation and Subsidiaries Welfare Benefit Plan. The vision benefit option of the Plan provides vision benefits.

Name And Address Of Company (Plan Sponsor)

Masonite Corporation
One Tampa City Center
Suite 300
Tampa, FL 33602

Plan Administrator

The Plan Administrator is Masonite Corporation, One Tampa City Center, Suite 300, Tampa, FL 33602, 1.866.554.4054. The Plan Administrator has delegated to VSP, the Claims Administrator, the authority and responsibility to interpret and construe the Visionl Benefit Option and to determine all factual and legal questions with respect to all initial claims for benefits and requests for review of denied claims. This delegated authority includes, but is not limited to, determinations of entitlement to benefits and the amounts of the benefits to be paid.

Agent For Service Of Legal Process

The person designated as agent for service of legal process for the Plan is Director, Employee Benefits, One Tampa City Center, Suite 300, Tampa, FL 33602.

Legal process may also be served upon the Plan Administrator or Plan Sponsor.

Identification Numbers

- The Plan number is 510.
- The Company's federal tax identification number (EIN) is 64-0198020.

Plan Fiscal Year

The Plan's fiscal year ends December 31.

Funding

You are responsible (through your benefit contributions) for paying the entire cost of the contribution for yourself and your family. You are also responsible for coinsurance, copayments and deductibles that may be required under the terms of this SPD.

The benefits provided under the Plan will be paid, to the extent permitted under ERISA and the tax code, from Employee contributions. Nothing in this plan will be construed to require the Company to maintain any fund for its own contributions or segregate any amount which it is obligated to contribute for the benefit of any Participant, and no Participant or other person will have any claim against, right to, or security or other interest in, any fund, account or asset of the Company from which any payment under the Plan may be made.

Plan Sponsor's Right To Change Or End The Plan

Amendment or Termination: The Company, acting through its Board of Directors or the Board's delegates, may amend, modify, or terminate this Plan at any time in any manner or with respect to any individual, including but not limited to Employees, eligible Dependents, retirees and disabled individuals, in its sole discretion. The Company reserves the right to modify the Plan to provide different cost sharing between the Company and Participants, at any time. Any amendment adopted will be in writing and

executed by the individual so authorized by the Company. Coverage upon Plan termination will be governed by the terms of the SPD. Nothing in this document, the SPD, or the Plan shall be construed to provide vested, nonforfeitable, nonterminable, or nonchangeable benefits or rights thereto.

FRAUD

Coverage for you or your dependents will be terminated if you or your dependent: submit fraudulent, altered, or duplicate billings and/or allow another party not covered under the Plan to use your or your dependent's coverage.

Plan Not a Contract of Employment

Your participation in the Plan does not guarantee your continued employment with the Company. All employees remain subject to discharge, discipline, or layoff to the same extent as if the Plan had not been put into effect. The benefits offered under the Plan are in no way vested or guaranteed.

PARTICIPATING EMPLOYERS

United States affiliates and subsidiaries of the Company may adopt the Plan, subject to the Company's consent. Any affiliate or subsidiary of the Company that participates in the Plan cannot amend or terminate the Plan itself, but it may, acting through its Board of Directors or delegate, and subject to the consent of the Company, terminate its participation in the Plan or any of the Plan's benefit programs.

Statement of ERISA Rights
The Vision Benefit Option offered under the Plan is an employee welfare benefit plan covered by the Employee Retirement Income Security Act of 1974 (ERISA) As a participant in the Plan, you are entitled to certain rights and protections under ERISA.

ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits
Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage
Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description for information concerning your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions
If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Although the Plan Sponsor expects to continue the Plan indefinitely, it reserves the right of discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Plan Sponsor's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Plan Sponsor does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Plan Sponsor decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Plan Sponsor and others as may be required by any applicable law.

IMPORTANT VSP CONTACT INFORMATION

Member Service – 1.800.877-7195 (for hearing impaired – TTD 1.800.428.4833)

VSP Web Site Address – www.vsp.com

VISION SERVICE PLAN - SCHEDULE OF BENEFITS

ELIGIBILITY - WAITING PERIOD

Effective January 1, 2010

Masonite Corporation and all subsidiaries.	
Salaried	You are eligible for the Plan on the 1st Day of the Month following or coincident with your Date of Hire.
Hourly Non- Union	You are eligible for the Plan on the 1st Day of the Month following or coincident with your Date of Hire.
Vandalia Union	You are eligible for the Plan on the 1st Day of the Month following or coincident with your Date of Hire.