GOLDEN WEST DENTAL & VISION

Exhibit B

VISION PLAN 89E
COPAYMENT SCHEDULE

Vision care treatment must be provided by a current member of the Golden West Vision Panel.

PROCEDURE	MEMBER PAYS
SERVICES	
Visual Analysis	$ 39.00
CONTACT LENSES (Soft)	**COST PER LENS**
Daily Wear	
Regular Soft	40.00
Tinted	45.00
Toric	70.00
Tinted Toric	80.00
Custom Toric	105.00
Aphakic (Post Cataract)	80.00
Opaque	65.00
Toric Opaque	95.00
Bifocal	100.00
Super Thin	40.00
Extended Wear	
Regular Soft	40.00
Tinted	45.00
Toric	85.00
Aphakic (Post Cataract)	90.00
Disposable & Frequent Replacement	10% Discount*
CONTACT LENSES (Rigid)	**COST PER LENS**
Hard Lens (P.M.M.A.)	$ 30.00
Gas Permeable (Daily Wear)	45.00
Gas Permeable (Extended Wear)	60.00
Bifocal	140.00
Toric	70.00
COMPLETE FITTING AND THREE-MONTH FOLLOW-UP, CAREKIT, AND TRAINING FOR CONTACT LENSES	
Daily Wear	
Regular Soft, Tinted, Thin, or Hard	45.00
Disposable & Frequent Replacement	45.00
All Others	
Toric, Extended Wear, Bifocal, Gas Permeable, Monovision, or Aphakic (Post Cataract)	112.00
FRAMES AND LENSES	
Lenses (All sizes)	25% Discount*
Frames (All sizes)	25% Discount*
Eyeglass Case (with purchase of eyeglasses)	NO CHARGE
Eyeglass Adjustments (with purchase of eyeglasses)	NO CHARGE
Sunglasses	25% Discount*

LIMITATIONS AND EXCLUSIONS

1. Medical Eye services will be excluded from optometry services.
2. Any procedure not listed on copayment schedule may be available at the Optometrist's Usual and Customary Fees.
3. There will be a charge for broken appointments without notification according to the policy of the optometry office.
4. Follow-up care for contact lenses shall be limited to a period of time not to exceed three (3) months. Additional visits are subject to an office visit charge.
5. Dispensing or prescribing of drugs.
6. Procedures or services determined by the Plan to be special or unusual including, but not limited to, orthoptics, vision training, and subnormal vision aids.
7. Services for injuries or conditions which are covered under Worker's Compensation or Employer's Liability Laws. Services which are provided without cost to the member by any municipality, county, or other political subdivision.
8. In the event that patient desires to be hospitalized for any ocular procedure, the cost will be borne by the patient.
9. Treatment required for conditions resulting from major disaster or epidemic or military-service-connected conditions.
10. Any experimental procedures.
11. Services that cannot be performed because of the general health of the patient.

A minor fitting fee of $30 is applicable in lieu of the complete fitting fee if the patient receives contact lenses elsewhere. Payment is due at time services are rendered.

*Not to be combined with any other offer.

Golden West Dental & Vision Uniform Matrix 89E Vision Plan

This benefit summary is intended to help you compare coverage, benefits, and limitations and is a summary only. For a more detailed description of coverage, benefits, and limitations, please contact Golden West. This comparative benefit summary is updated annually, or more often if necessary to be accurate. The most current version of this comparative benefit summary is available at www.goldenwestdental.com. The Evidence of Coverage (EOC) should be consulted for a detailed description of benefits, limitations, exclusions, and the exact terms and conditions of your coverage. You have a right to review the EOC prior to enrollment. To obtain a copy of the EOC, please call (800) 995-4124. If you need further assistance, please contact the Department of Managed Health Care at (888) HMO-2219.

BENEFIT DESCRIPTION	COPAYMENTS	LIMITATIONS/EXCLUSIONS
Annual Deductibles	There is no annual deductible.	
Calendar Year Maximums	There are no calendar year maximums on treatment provided by a network vision provider.	
Lifetime Maximums	There are no lifetime maximums on treatment provided by a network vision provider.	
Professional Services:		
Visual Analysis	$39	Medical Eye services excluded.
Contact Lens	$40 - $140 per lens	Minor fitting fee of $30 is applicable in lieu of the complete fitting fee if the patient receives contact lens elsewhere.
Frames	25% discount	Not to be combined with any other offier.
Lens	25% discount	Not to be combined with any other offier.
Sunglasses	25% discount	Not to be combined with any other offier.
Emergency Services*		Not a covered benefit of this plan.
Outpatient Services*		Not a covered benefit of this plan.
Hospitalization Services*		Not a covered benefit of this plan.
Emergency Health Coverage*		Not a covered benefit of this plan.
Ambulance Services*		Not a covered benefit of this plan.
Prescription Drug Coverage*		Not a covered benefit of this plan.
Durable Medical Equipment*		Not a covered benefit of this plan.
Mental Health Services*		Not a covered benefit of this plan.
Residential Treatment*		Not a covered benefit of this plan.
Chemical Dependency Services*		Not a covered benefit of this plan.
Home Health Services*		Not a covered benefit of this plan.
Custodial Care and Skilled Nursing Facilities*		Not a covered benefit of this plan.

*Golden West is required by regulation to provide this information. Golden West provides Dental, Orthodontic, and Vision benefits only.