OCCUPATIONAL
EYEWEAR
NETWORK, INC

Vision Plan Description
for Total Heath Care USA Commercial Groups

Eligibility: All eligible members are entitled to:

- Examination – every calendar year
- Frame and Lenses, or Contacts - every two calendar years

Reimbursement Schedule:

ITEM	MEMBER PAYS
Comprehensive Eye Exam	-0-
Contact Lens Fitting Fee	Retail
Frame (up to $80.00 retail)	-0-
Frame (over $80.00 retail)	Retail, less 30%, Less $24.00
Lenses: (CR-39 or Glass)	
Single Vision	-0-
Bifocal	-0-
Trifocal	-0-
Contact Lenses:	
Elective	Retail less $80.00
Medically Necessary	Retail less $140.00

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Options available to eligible Total Health Care USA Commercial Groups Members:

ITEM	MEMBER PAYS
Polycarbonate Lenses	$30.00
Hi Index	$60.00
Progressive – Standard	$50.00
Progressive – Midrange	$80.00
Progressive – Premium	$125.00
Solid Tint	$10.00
Gradient Tint	$12.00
Oversize lenses	-0-
UV Coating	$15.00
Scratch Coat	$15.00
AR Coating – Standard	$40.00
AR Coating – Premium	$55.00
AR Coating - Hydrophobics	$79.00
Photochromic Lenses	$20.00
Transition Lenses	$70.00
Polarized lenses	$70.00

Notes:

- For any item not listed above – give a 20% discount off retail pricing.
- Progressive Upgrade: Bill plan for Trifocal reimbursement.
- Utilize optical lab of choice for lens fabrication.
- Contact Lens benefit is in lieu of eyeglass benefit.
- A prior authorization is required for medically necessary contact lenses.

Exclusions – No payment will be made for the following:

- Eyeglasses for members not requiring corrective lenses.
- Charges for any service or materials not covered by this program.
- Medical or surgical treatment.
- Services provided or glasses ordered before member is eligible for coverage or after termination of coverage.
- Replacement of lost lenses or frames, unless member meets all eligibility requirements.
- Replacement of scratched lenses.
- Prescription safety glasses.

Solid Rock Management
Davis Vision Plan Program
Benefit Illustration

Plan Features:

Copayment:	Exam	$10.00
	Materials	$25.00

	Benefit Details	
	In-network	**Out-of-network**
Eye Exams	Covered in Full after Copay	$ 46.00 Maximum after Copay
Frequency: Every 12 Months		
Lenses		
Frequency: Every 24 Months		
Single Vision	Covered in Full after Copay	$ 47.00 Maximum after Copay
Lined Bifocal	Covered in Full after Copay	$ 66.00 Maximum after Copay
Lined Trifocal	Covered in Full after Copay	$ 85.00 Maximum after Copay
Lenticular	Covered in Full after Copay	$125.00 Maximum after Copay

Designer plan spectacle lens In-Network benefits include full coverage of oversized and tinted lenses.

Contact Lenses*		
Frequency: Every 24 Months		
Medically Necessary	Covered in Full after Copay	$210.00 Maximum after Copay
Elective	$135.00**	$105.00** Maximum
Frames		
Frequency: Every 24 Months		
Frames	$135.00 Retail Allowance*	$ 47.00 Maximum after Copay

*If you choose contact lenses, you will not be eligible to receive lenses for 24 months and a frame for 24 months following the date contacts were obtained.

*Frames from Davis' Fashion or Designer collections are covered in full in excess of this plan's materials copay. Frames from Davis' Premier collection are covered in full in excess of a $25 copay applied in addition to the plan's materials copay. Frames from a Davis network provider that are not in the collections are covered up to the plan's retail allowance in excess of the plan's materials copay.

** In-network elective contact lenses from Davis Vision's formulary are covered in full in excess of the copay. In-network elective contacts lenses that are not part of the formulary are covered up to the elective contact allowance and the copay is waived.

One Year Lock-In/Lock-Out

- Your election to enroll in or waive Vision Plan coverage must remain in effect for 12 months (i.e., July 1, 2009 through June 30, 2010). This means:
- If you enroll in the Plan, you will not be able to drop coverage for yourself or your dependents until the Annual Enrollment in 2010.
- If you elect not to enroll in the Plan or do not enroll an eligible spouse/child, you may not enroll until Annual Enrollment in 2010.

Important Information: This policy provides vision care limited benefits health insurance only. It does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department. Coverage is limited to those charges that are necessary for a routine vision examination. Co-pays apply. The plan does not pay for: orthoptics or vision training and any associated supplemental testing; medical or surgical treatment of the eye; and eye examination or corrective eyewear required by an employer as a condition of employment; replacement of lenses and frames that are furnished under this plan, which are lost or broken (except at normal intervals when services are otherwise available or a warranty exists). The plan limits benefits for blended lenses, oversized lenses, photochromic lenses, tinted lenses, progressive multifocal lenses, coated or laminated lenses, a frame that exceeds plan allowance, cosmetic lenses; U-V protected lenses and optional cosmetic processes. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract #GP-1-DAVIS-05-VIS et al.

This handout is for illustrative purposes. You will receive benefit booklets when your enrollment application is processed. If there is a discrepancy between this handout and your benefit booklet, the benefit booklet prevails.