

Benefit Summary

for Vision has been prepared for the employees of:

DATAWORKFORCE, L.P.

Full Feature Plan

Frequency of Service:

Exam	every 12 months
Materials:	
Lenses	every 24 months
Frames	every 24 months
Or	
Contact Lenses (in lieu of frames & lenses)	every 24 months

Note: If you chose 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.

Copayment:

Exam	\$20
Materials	\$20

Benefits (after Copayment):

	<u>In-Network</u>	<u>Out-of-Network</u>
Eye Exams	covered in full	up to \$46.00
Single Vision Lenses	covered in full	up to \$47.00
Lined Bifocal Lenses	covered in full	up to \$66.00
Lined Trifocal Lenses	covered in full	up to \$85.00
Lenticular Lenses	covered in full	up to \$125.00
Frames	\$115 Retail Allowance*	up to \$47.00
Contact Lenses		
Medically Necessary	covered in full	up to \$210.00
Elective	\$105.00**	up to \$105.00**

* Approximately 15,000 frames are covered in full. Frames not fully covered are offered at a discounted cost. If you select a frame that exceeds the retail allowance, the plan will cover 20% of the amount above the allowance. You must pay the rest.

** Copayment does not apply to elective contact lenses.

Two Year Lock-In/Lock-Out

- Your election to enroll in or waive Vision Plan coverage must remain in effect for 24 months (i.e., July 1, 2004 through June 30, 2006). 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 2006.
- 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 2006.

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 to prevent, diagnose and treat a vision condition. 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; lenses and frames that are furnished under this plan, which are lost or broken (except at normal intervals when services are otherwise available). 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-VSN-96-1 et al

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


GUARDIAN®