

## Vision Benefit Summary

### About Your Benefits:

Full Feature	
Network	VSP Network Signature Plan
Copay	
Exams Copay	\$ 10
Materials Copay (waived for elective contact lenses)	\$ 20
Sample of Covered Services	You pay (after copay if applicable):
	In-networkOut-of-network
Eye Exams	\$0Amount over \$50
Single Vision Lenses	\$0Amount over \$48
Lined Bifocal Lenses	\$0Amount over \$67
Lined Trifocal Lenses	\$0Amount over \$86
Lenticular Lenses	\$0Amount over \$126
Frames	80% of amount over \$150Amount over \$48
Contact Lenses (Elective)	Amount over \$150Amount over \$120
Contact Lenses (Medically Necessary)	\$0Amount over \$210
Contact Lenses (Evaluation and fitting)	15% off UCRNo discounts
Cosmetic Extras	Avg. 30% off retail priceNo discounts
Glasses (Additional pair of frames and lenses)	20% off retail price^No discounts
Laser Correction Surgery Discount	Up to 15% off the usual charge or 5% off promotional priceNo discounts
Service Frequencies	
Exams	Every 12 months
Lenses (for glasses or contact lenses)††	Every 12 months
Frames	Every 24 months
Network discounts (cosmetic extras, glasses and contact lens professional service)	Limitless within 12 months of exam.

‡‡Benefit includes coverage for glasses or contact lenses, not both.

This is only a partial list of vision services. Your certificate of benefits will show exactly what is covered and excluded.

^ For the discount to apply your purchase must be made within 12 months of the eye exam. In addition Full-Feature plans offer 30% off additional prescription glasses and nonprescription sunglasses, including lens options, if purchased on the same day as the eye exam from the same VSP doctor who provided the exam.

***This document is a summary of the major features of the referenced insurance coverage. It is intended for illustrative purposes only and does not constitute a contract. The insurance plan documents, including the policy and certificate, comprise the contract for coverage. The full plan description, including the benefits and all terms, limitations and exclusions that apply will be contained in your insurance certificate. The plan documents are the final arbiter of coverage. Coverage terms may vary by state and actual sold plan.***

## **EXCLUSIONS AND LIMITATIONS**

*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-I-VSN-96-VIS et al.

### **Laser Correction Surgery:**

Up to 15% off the usual charge or 5% off promotional price for vision laser surgery. Members' out-of-pocket costs are limited to \$1,800 per eye for LASIK and \$1,500 per eye for PRK.

Laser surgery is not an insured benefit. The surgery is available at a discounted fee. The covered person must pay the entire discounted fee. In addition, the laser surgery discount may not be available in all states.