



Summary of Benefits

Vision Benefit Summary

Group ID:	00489910	Coverage Type:	Contributory
Group Name:		Class:	0001 ALL ELIGIBLE EMPLOYEES
Waiting Period:	1st of the month following 30 day(s)	As of Date:	03/08/2017

Plan Information

Your network is the VSP - Choice Full Feature

Coverage Information

	VSP - Choice Full Feature	
What's the most cost-effective way to use vision benefits?	You may go to any eye doctor however, if you go to a VSP network provider you will usually pay less.	
	In-Network	Out-Of-Network
Co-Pay		
First service provided	Not applicable	
Exams	Exams \$10.00	
Materials	waived for conventional and planned replacement contact lenses \$25.00	
How often can I obtain service?	Exams: Once a year. Lenses: Once a year. Frames: Once every other year. Materials: Once a year.	
	In-Network	Out-Of-Network
Eye exams	Copay applies	Amount over: \$39.00
Lenses		
Single vision lenses	Copay applies	Amount over: \$23.00
Lined bifocal lenses	Copay applies	Amount over: \$37.00
Lined trifocal lenses	Copay applies	Amount over: \$49.00
Lenticular lenses	Copay applies	Amount over: \$64.00

	VSP - Choice Full Feature	
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	In-Network	Out-Of-Network
Contact Lenses		
Conventional	Amount over: \$130.00	Amount over: \$100.00
Planned replacement and disposable	Amount over \$130.00	Amount over: \$100.00
Medically necessary	Copay Applies	Amount over: \$210.00
Evaluation and fitting	15% off professional fee	Not Covered
Frames	\$130.00, 20% discount on amount over \$130.00.	Amount over: \$46.00
Lens & Frame Allowance	No discounts	No discounts
Cosmetic Extras	Discounted at an average of 20%-25% off providers UCR.	No discounts
Laser correction surgery	Average 15% discount off usual price or 5% off promotional price.	No discounts

Vision and General Exclusions

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;
- 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-VSN-96-VIS et al.

Laser Correction Surgery

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.



Members will receive 20% off unlimited additional pairs of prescription glasses and non prescription sunglasses valid through any VSP doctor within 12 months of the last covered exam.

This Benefit Summary is for illustrative purposes. Your benefits booklet will show exactly what is covered and/or excluded under your plan. If there is a discrepancy between this Benefit Summary and your benefit booklet, the benefit booklet prevails.

Definitions shown on this site are in summary form and are for general informational purposes. The terms of the insurance contract prevails.

