



**Integrated Data System Inc.
Vision Service Plan (VSP) Full Feature Program
Benefit & Cost Illustration**

Plan Features:

Copayment: Exam: \$10.00
Materials: \$10.00

Benefit Details

	In-network	Out-of-network
Eye Exams Frequency: Every 12 Months	Covered in Full after \$10.00 Copay	\$ 46.00 Maximum after Copay
Lenses Frequency: Every 12 Months	Covered in Full after \$10.00 Copay	
Single Vision	Covered in Full after \$10.00 Copay	\$ 47.00 Maximum after Copay
Bifocal	Covered in Full after \$10.00 Copay	\$ 66.00 Maximum after Copay
Trifocal	Covered in Full after \$10.00 Copay	\$ 85.00 Maximum after Copay
Lenticular	Covered in Full after \$10.00 Copay	\$125.00 Maximum after Copay
Contact Lenses* Frequency: Every 12 Months		
Medically Necessary	Covered in Full after \$10.00 Copay	\$210.00 Maximum after Copay
Elective	\$120.00 Maximum (Copay Does Not Apply)	
Frames Frequency: Every 24 Months	\$120.00 Retail Allowance**	\$ 47.00 Maximum after Copay

*If you choose contact lenses, you will not be eligible to receive lenses for 12 months and a frame for 24 months following the date contacts were obtained. For elective and necessary contact lenses, we will pay up to the benefit limits towards an examination, contact lens evaluation fee, fitting costs and materials.

**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.

Note: Lens coverage includes polycarbonate lenses for children up to the plan's non-student dependent child age limits 20 (26 full-time student).

One Year Lock-In/Lock-Out

- o Your election to enroll in or waive Vision Plan coverage must remain in effect for 12 months (i.e., July 1, 2006 through June 30, 2007). This means:
- o If you enroll in the Plan, you will not be able to drop coverage for yourself or your dependents until the Annual Enrollment in 2007.
- o 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 2007.

VSP: www.vsp.com
1800 877-7195

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-VSN-96-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.