GUARDIAN℠

Benefits Guide

THIS BENEFITS GUIDE HIGHLIGHTS THE PLAN BENEFITS AND FEATURES CHOSEN BY YOUR EMPLOYER. THIS IS NOT AN INSURANCE CONTRACT OR A COMPLETE DESCRIPTION OF PLAN PROVISIONS. A COMPREHENSIVE BENEFIT DESCRIPTION IS CONTAINED IN THE GROUP POLICY AND/OR BOOKLET THAT WILL BE ISSUED TO YOUR EMPLOYER UPON APPROVAL OF COVERAGE. IF ANY CONFLICT EXISTS BETWEEN THE PLAN DOCUMENTS AND THIS BENEFITS GUIDE, THE PROVISIONS OF THE PLAN DOCUMENTS WILL PREVAIL.

00460832/00000.0/A /0001/A77166/99999999/0000/PRINT DATE: 11/03/10

WELCOME

Greetings! This Benefits Guide has been designed to introduce you to the benefits plan provided to you by your employer, CYPRESS-FAIRBANKS I.S.D. , and administered by Guardian.

On the next page you will find some important contact information. We hope that this will make it easier for you to use your benefits when they become effective.

The guide that follows the contact information page summarizes the major features of the coverages for which you may be eligible:

- Vision Care

Ensuring your satisfaction is our most important goal. If you need any information or assistance with your benefits, please call Member Services at the appropriate toll-free telephone number listed on the following page, or visit us online at www.guardianlife.com.

We are pleased to have this opportunity to serve you. We look forward to providing the best service to you and your employer for many years to come.

C O N T A C T S

claims to submit?

need more information?

Vision Care

Vision Service Plan
Out-of-Network Provider Claims
P.O. Box 997105
Sacramento, CA 95899-7105

1-800-877-7195
6:00 a.m. - 6:00 p.m.
Pacific Time
Mon - Fri

vision

what's covered?

	For Services Furnished By An In-Network Provider			
	You Pay	Plan Pays	Every	Up To
Vision Exam	$20.00	100%	12 months	none
Standard Frames	$20.00	100%	24 months	$130.00 retail plus 20% of balance.
Standard Lenses	$20.00	100%	12 months	none
Contacts (Elective)	-	100%	12 months	$130.00
Contacts (Necessary)	$20.00	100%	12 months	none

Discount: If you receive an exam, and lenses or frames from a preferred provider, you will receive a 20% discount on an unlimited number of prescription glasses from the same provider. You may also receive a discount on the costs of evaluation and fitting of contact lenses. No discount applies to contact lenses or materials. The discount is available for 12 months after the initial examination.

	For Services Furnished by an Out-of-Network Provider			
	You Pay	Plan Pays	Every	Up To
Vision Exam	$20.00	100%	12 months	$50.00
Standard Frames	$20.00	100%	24 months	$48.00
Lenses				
Single	$20.00	100%	12 months	$48.00
Bifocal	$20.00	100%	12 months	$67.00
Trifocal	$20.00	100%	12 months	$86.00
Lenticular	$20.00	100%	12 months	$126.00
Contacts (Elective)	-	100%	12 months	$120.00
Contacts (Necessary)	$20.00	100%	12 months	$210.00

what isn't covered?

Here are some of the most common situations where benefits will not be paid. For complete details, please refer to the booklet which your plan administrator can provide.

- Optional cosmetic processes, orthoptics or vision training, and Medical or surgical eye treatments.
- Eye Exams or corrective eyewear required by an employer as a condition of employment.
- Replacement of lost or broken frames and lenses furnished under this plan, except at normal intervals.
- Two pairs of glasses in lieu of bifocals.
- Frames that cost more than the plan allowance.
- The following types of lenses: cosmetic, plano, blended, oversize, progressive multifocal, and UV protected.
- Coating or laminating of the lens or lenses.
- Photochromic and tinted lenses, except for Pink #1 & #2.

how do I file a claim?

- If you go to an out-of-network provider, pay the entire bill at the time you receive the services. Then, send VSP the following:

  - An itemized bill listing the services you received
  - The name, address and phone number of the out-of-network provider
  - The covered member's VSP member id number
  - The covered member's name, phone number and address
  - The name of the group that provides your VSP coverage
  - The patient's name, date of birth, phone number and address
  - The patient's relationship to the covered VSP member (such as "self," "spouse," "child," "student," etc.)

  Please keep a copy of the information for your records, and send the originals to:

  Vision Service Plan
  Attn: Out-of-Network Provider Claims
  P.O. Box 997105
  Sacramento, CA 95899-7105

further questions?

- Call VSP at 1-800-877-7195
  6:00 a.m. - 6:00 p.m.
  Pacific Time
  Mon-Fri
- To ask questions via e-mail, view plan information, or find a preferred vision provider in your area, go to www.vsp.com
- Log on to www.GuardianAnytime.com, our secure website where you can access your Guardian benefits information. It's available to you 24 hours a day, 7 days a week. Anytime, anywhere you have an internet connection, you'll be able to:

  - Review your benefits
  - Look up coverage amounts
  - Check the status of a claim
  - Print forms and plan materials
  - Access significant discounts on goods and services, from home office supplies to flowers (Certain exclusions apply and availability may vary based on company location.)
  - And so much more!

  To register, go to www.GuardianAnytime.com.