

Guardian Vision Featuring the VSP Network

The Guardian's Full Feature Plans A, B and C differ by Service Intervals as Shown Below.
 The Exam Plus Plan Covers an Exam Every 12 Months and Discounts for Lenses and Frames.
 Exam Plus Allowance Plans are offered in two Intervals 12/12 or 12/24 for Exam/Materials.



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* These rates are for effective dates 7/1/07 through 12/31/07.
 * All Rates are guaranteed for one year. For 2 year rates, multiply the rates by 1.025.
 * Rate assume 75% participation.
 * Use for groups tied to Dental or Medical with 2-9 eligible employees or tied to Dental for 10-15 eligible employees.
 * Rates assume Vision sold with Guardian Dental. For 10-15 employees, when vision is sold with Guardian Medical, multiply rates by .96.
 * Rates are based on 4-tier enrollment.
 * Multiply the Employee Only rate by the following to convert to 2-tier or 3-tier rates (note Employee Only rate doesn't change):
 2-tier 1.00
 3-tier 1.00
 EE Only: 1.00 EE Only: 1.00
 EE & One: 2.15 EE & Dept(s): 1.52
 EE & Sp & Chren): 2.67

	Exam Plus	Plan A	Plan B	Plan C	Exam Plus Allowance
Exams	12 Months	12 Months	12 Months	12 Months	12 Months
Lenses	n/a	24 Months	12 Months	12 Months	n/a
Frames	n/a	24 Months	24 Months	12 Months	n/a
Materials	n/a	n/a	n/a	n/a	12 or 24 Months

Exam Plus Copays	2-4 Employees				5-9 Employees				10-15 Employees			
	EE Only	EE+SP	EE+CH	Family	EE Only	EE+SP	EE+CH	Family	EE Only	EE+SP	EE+CH	Family
\$0	\$4.90	\$8.25	\$8.41	\$13.31	\$4.62	\$7.77	\$7.93	\$12.55	\$1.53	\$2.57	\$2.62	\$4.15
\$10	\$3.77	\$6.35	\$6.47	\$10.24	\$3.55	\$5.98	\$6.10	\$9.66	\$1.18	\$1.98	\$2.02	\$3.20
\$20	\$2.56	\$4.31	\$4.39	\$6.95	\$2.41	\$4.06	\$4.14	\$6.55	\$0.86	\$1.45	\$1.48	\$2.34

Exam Plus Allowance 12/12

Copoly/Allowance	2-4 Employees				5-9 Employees				10-15 Employees			
	EE Only	EE+SP	EE+CH	Family	EE Only	EE+SP	EE+CH	Family	EE Only	EE+SP	EE+CH	Family
\$0/\$50	\$5.29	\$8.90	\$9.08	\$14.37	\$4.99	\$8.39	\$8.56	\$13.55	\$4.64	\$7.81	\$7.97	\$12.61
\$10/\$50	\$4.85	\$8.16	\$8.32	\$13.17	\$4.57	\$7.69	\$7.85	\$12.42	\$4.26	\$7.16	\$7.31	\$11.56
\$0/\$100	\$7.54	\$12.69	\$12.94	\$20.47	\$7.10	\$11.96	\$12.20	\$19.30	\$6.62	\$11.14	\$11.36	\$17.97
\$10/\$100	\$7.08	\$11.93	\$12.16	\$19.25	\$6.68	\$11.24	\$11.46	\$18.14	\$6.22	\$10.47	\$10.67	\$16.89

Exam Plus Allowance 12/24

Copoly/Allowance	2-4 Employees				5-9 Employees				10-15 Employees			
	EE Only	EE+SP	EE+CH	Family	EE Only	EE+SP	EE+CH	Family	EE Only	EE+SP	EE+CH	Family
\$0/\$50	\$4.17	\$7.02	\$7.16	\$11.33	\$3.93	\$6.62	\$6.75	\$10.68	\$3.66	\$6.15	\$6.28	\$9.93
\$10/\$50	\$3.72	\$6.26	\$6.39	\$10.11	\$3.51	\$5.90	\$6.02	\$9.53	\$3.26	\$5.49	\$5.60	\$8.85
\$0/\$100	\$5.29	\$8.90	\$9.08	\$14.37	\$4.99	\$8.39	\$8.56	\$13.55	\$4.64	\$7.81	\$7.97	\$12.61
\$10/\$100	\$4.85	\$8.16	\$8.32	\$13.17	\$4.57	\$7.69	\$7.85	\$12.42	\$4.26	\$7.16	\$7.31	\$11.56

Full Feature Plan C

Copsays	2-4 Employees				5-9 Employees				10-15 Employees			
	EE Only	EE+SP	EE+CH	Family	EE Only	EE+SP	EE+CH	Family	EE Only	EE+SP	EE+CH	Family
\$0	\$13.39	\$22.55	\$22.99	\$36.39	\$12.63	\$21.25	\$21.67	\$34.30	\$9.91	\$16.68	\$17.01	\$26.92
\$0/\$10	\$12.27	\$20.65	\$21.06	\$33.33	\$11.57	\$19.47	\$19.86	\$31.42	\$9.08	\$15.28	\$15.59	\$24.66
\$10	\$11.84	\$19.93	\$20.33	\$32.17	\$11.16	\$18.79	\$19.16	\$30.32	\$8.76	\$14.75	\$15.04	\$23.80
\$10/\$10	\$10.83	\$18.23	\$18.59	\$29.42	\$10.21	\$17.19	\$17.53	\$27.74	\$8.01	\$13.49	\$13.75	\$21.77
\$10/\$20	\$9.61	\$16.18	\$16.50	\$26.11	\$9.06	\$15.25	\$15.55	\$24.61	\$7.11	\$11.97	\$12.21	\$19.32
\$10/\$25	\$8.46	\$14.24	\$14.52	\$22.98	\$7.97	\$13.42	\$13.69	\$21.66	\$6.26	\$10.53	\$10.74	\$17.00
\$20/\$20	\$7.87	\$13.25	\$13.51	\$21.38	\$7.42	\$12.49	\$12.73	\$20.15	\$5.82	\$9.79	\$9.99	\$15.80

Full Feature Plan B

Copsays	2-4 Employees				5-9 Employees				10-15 Employees			
	EE Only	EE+SP	EE+CH	Family	EE Only	EE+SP	EE+CH	Family	EE Only	EE+SP	EE+CH	Family
\$0	\$11.40	\$19.19	\$19.57	\$30.98	\$10.75	\$18.09	\$18.45	\$29.20	\$8.44	\$14.20	\$14.48	\$22.92
\$0/\$10	\$10.40	\$17.51	\$17.86	\$28.26	\$9.81	\$16.51	\$16.83	\$26.64	\$7.70	\$12.95	\$13.21	\$20.91
\$10	\$10.02	\$16.87	\$17.20	\$27.22	\$9.45	\$15.90	\$16.22	\$25.66	\$7.41	\$12.48	\$12.73	\$20.14
\$10/\$10	\$9.12	\$15.35	\$15.65	\$24.77	\$8.59	\$14.47	\$14.75	\$23.35	\$6.74	\$11.35	\$11.58	\$18.32
\$10/\$20	\$8.07	\$13.58	\$13.85	\$21.92	\$7.61	\$12.80	\$13.06	\$20.66	\$5.97	\$10.05	\$10.24	\$16.21
\$10/\$25	\$7.09	\$11.93	\$12.17	\$19.25	\$6.68	\$11.25	\$11.47	\$18.15	\$5.24	\$8.83	\$9.00	\$14.25
\$20/\$20	\$6.51	\$10.95	\$11.17	\$17.68	\$6.13	\$10.32	\$10.53	\$16.66	\$4.81	\$8.10	\$8.26	\$13.07

Full Feature Plan A

Copsays	2-4 Employees				5-9 Employees				10-15 Employees			
	EE Only	EE+SP	EE+CH	Family	EE Only	EE+SP	EE+CH	Family	EE Only	EE+SP	EE+CH	Family
\$0	\$9.47	\$15.94	\$16.25	\$25.72	\$8.93	\$15.03	\$15.32	\$24.25	\$7.01	\$11.80	\$12.03	\$19.04
\$0/\$10	\$8.70	\$14.64	\$14.93	\$23.63	\$8.20	\$13.80	\$14.07	\$22.27	\$6.43	\$10.83	\$11.05	\$17.48
\$10	\$8.28	\$13.93	\$14.21	\$22.49	\$7.80	\$13.14	\$13.40	\$21.20	\$6.13	\$10.31	\$10.52	\$16.64
\$10/\$10	\$7.56	\$12.73	\$12.98	\$20.55	\$7.13	\$12.00	\$12.24	\$19.37	\$5.60	\$9.42	\$9.61	\$15.21
\$10/\$20	\$6.75	\$11.37	\$11.59	\$18.35	\$6.37	\$10.72	\$10.93	\$17.30	\$5.00	\$8.41	\$8.58	\$13.58
\$10/\$25	\$5.95	\$10.02	\$10.22	\$16.17	\$5.61	\$9.45	\$9.63	\$15.25	\$4.41	\$7.42	\$7.57	\$11.97
\$20/\$20	\$5.45	\$9.17	\$9.35	\$14.80	\$5.14	\$8.65	\$8.82	\$13.95	\$4.03	\$6.78	\$6.92	\$10.94

Participation Rules:

- (a) **"TIED-TO" DENTAL:** Each EE & Dep with Guardian Dental, enrolls in Vision and each EE & Dep with Vision enrolls in the dental plan [I.E. an exact one-to-one match of Vision enrollment to the dental enrollment.]
- OR (b) **"TIED-TO" MEDICAL:** Each EE & Dep with Guardian Medical, enrolls in Vision and each EE & Dep with Vision enrolls in the medical plan [I.E. an exact one-to-one match of Vision enrollment to the medical enrollment.]

Vision Insurance Plan General Limitations and Exclusions: 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 orthotics 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 multi-focal 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.

The Guardian Life Insurance Company of America, New York, NY 10004