



Group Number: 00553739

Broome-Tioga Board of Coop Educational Services

All Eligible Employees - 26 Week Deductions

Here you'll find information about your following employee benefit(s). Be sure to review the enclosed - it provides everything you need to sign up for your Guardian benefits.

PLAN HIGHLIGHTS

- Vision

Questions? Concerns?

Helpline (888) 600-1600

Call weekdays, 7:00 AM to 8:30 PM, EST.

And refer to your plan number: 00553739

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Effective: November 01, 2018

Group Number: 00553739

Vision Benefit Summary

About Your Benefits:

Eye care is a vital component of a healthy lifestyle. With vision insurance, having regular exams and purchasing contacts or glasses is simple and affordable. The coverage is inexpensive, yet the benefits can be significant! Guardian provides rich, flexible plans that allow you to safeguard your health while saving you money. Review your plan options and see why vision insurance may be a great benefit for you.

Option 1: Visit any doctor with your **Full Feature** plan, but save by visiting any of the 50,000+ locations in the nation's largest vision network.

Option 2: Significant out-of-pocket savings available with your **Full Feature** plan by visiting one of Davis Vision's network locations including retail centers such as Wal-Mart®, JCPenney®, Sears®, Target®, Sam's Club®, Pearle®, and Visionworks®.

| Your Vision Plan | Option 1: VSP | | Option 2: Davis Vision | |
|--|--|-----------------------|--|-----------------------|
| Your Network is | VSP Choice Network | | Davis Vision | |
| Your Bi-weekly premium | \$ 5.47 | | \$ 4.78 | |
| You, spouse and child(ren) | \$ 11.75 | | \$ 10.28 | |
| Copay | | | | |
| Exams Copay | \$ 10 | | \$ 10 | |
| Materials Copay (waived for non-formulary elective contact lenses) | \$ 10 | | \$ 10 | |
| Sample of Covered Services | You pay (after copay if applicable): | | You pay (after copay if applicable): | |
| | <i>In-network</i> | <i>Out-of-network</i> | <i>In-network</i> | <i>Out-of-network</i> |
| Eye Exams | \$0 | Amount over \$39 | \$0 | Amount over \$50 |
| Single Vision Lenses | \$0 | Amount over \$23 | \$0 | Amount over \$48 |
| Lined Bifocal Lenses | \$0 | Amount over \$37 | \$0 | Amount over \$67 |
| Lined Trifocal Lenses | \$0 | Amount over \$49 | \$0 | Amount over \$86 |
| Lenticular Lenses | \$0 | Amount over \$64 | \$0 | Amount over \$126 |
| Frames | 80% of amount over \$150 ¹ | Amount over \$46 | 80% of amount over \$150* ² | Amount over \$48 |
| Contact Lenses (Elective) | Amount over \$150 | Amount over \$100 | N/A | N/A |
| Contact Lenses (Elective and conventional) | N/A | N/A | 85% of amount over \$150* | Amount over \$105 |
| Contact Lenses (Planned replacement and disposable) | N/A | N/A | 85% of amount over \$150* | Amount over \$105 |
| Contact Lenses (Medically Necessary) | \$0 | Amount over \$210 | \$0 | Amount over \$210 |
| Contact Lenses (Evaluation and fitting) | 15% off UCR | No discounts | No discounts | No discounts |
| Cosmetic Extras | Avg. 20-25% off retail price | No discounts | Avg. 40-60% off retail price | No discounts |
| Glasses (Additional pair of frames and lenses) | 20% off retail price** | No discounts | Courtesy discount from most providers | No discounts |
| Laser Correction Surgery Discount | Up to 15% off the usual charge or 5% off promotional price | No discounts | Up to 25% off the usual charge or 5% off promotional price | No discounts |

| Your Vision Plan | Option 1: VSP | Option 2: Davis Vision |
|---|-------------------------------------|--|
| Service Frequencies | | |
| Exams | Every calendar year | Every calendar year |
| Lenses (for glasses or contact lenses)†† | Every calendar year | Every calendar year |
| Frames | Every two calendar years††† | Every two calendar years |
| Network discounts (glasses and contact lens professional service) | Limitless within 12 months of exam. | Applies to first purchase & courtesy discount from most providers on subsequent purchases. |
| Dependent Age Limits | 26 | 26 |
| Visit www.GuardianAnytime.com and click on "Find a Provider" | | |

VSP

- ††Benefit includes coverage for glasses or contact lenses, not both.
- ** For the discount to apply your purchase must be made within 12 months of the eye exam.
- Charges for an initial purchase can be used toward the material allowance. Any unused balance remaining after the initial purchase cannot be banked for future use. The only exception would be if a member purchases contact lenses from an out of network provider, members can use the balance towards additional contact lenses within the same benefit period.
- †Extra \$20 on select brands
- †††. The VSP system considers contact lenses to be the equivalent of a full pair of eyeglasses (lenses and frames) so while the member can obtain contact lenses one year and standard eyeglass lenses the next year, the frames benefit would not be available until 24 months or two calendar years, depending on the plan design, after the date the member obtained the contact lenses.

Davis

- ††Benefit includes coverage for glasses or contact lenses, not both.
- Contact lenses from Davis Vision's Collection are available at most private practice locations with Full Feature and Materials Only plans. Contacts from the collection are covered in full including fitting and evaluation, in excess of the plan's materials copay. Elective contacts that are not part of the Collection are covered up to the plan's elective contact lens allowance and the materials copay is waived.
- *Due to lower prices available at Wal-mart and Sam's Club locations, discounts do not apply. Members will pay 100% of the amount over their allowance.
- For Davis Vision, complete eyeglasses must be purchased at one time from one provider. For example, if a member purchases only lenses, he or she cannot purchase frames later in the same benefit period. The member is not eligible for new vision materials until the next benefit period. Only charges for an initial purchase can be used toward the material allowance. Any unused balance remaining after the initial purchase cannot be banked for future use.
- †Extra \$50 at Visionworks stores

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. The premium amounts reflected in this summary are an approximation; if there is a discrepancy between this amount and the premium actually billed, the latter prevails.

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits including access to an image of your ID Card. Your on-line account will be set up within 30 days after your plan effective date.

Need Assistance?

Call the Guardian Helpline (888) 600-1600, weekdays, 8:00 AM to 8:30 PM, EST. Refer to your member ID (social security number) and your plan number: 00553739.

Please call the Guardian Helpline if you need to use your benefits within 30 days of plan effective date. Please note, self-serve options over the phone or online at Guardian Anytime are not available until the case is fully implemented, please wait to speak to a live agent when calling the Guardian Helpline.

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-DAVIS-05-VIS et al. Contract #GP-I-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.

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THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

Group Insurance Enrollment Form

Page 1 of 4

Guardian Life, P.O. Box 981585,
El Paso, TX 79998-1585

Please print clearly and mark carefully.

| | | |
|---|------------------------------------|---------------------------|
| Employer Name: Broome-Tioga Board of Coop Educational Services | Group Plan Number: 00553739 | Benefits Effective: _____ |
| PLEASE CHECK APPROPRIATE BOX | Initial Enrollment | Re-Enrollment |
| Increase Amount | Family Status Change | Add Employee/Dependents |
| | | Drop/Refuse Coverage |
| | | Information Change |

Class: All Eligible Employees - 26 Division: _____ Subtotal Code: _____ (Please obtain this from your Employer)
Week Deductions

| | | | |
|--|--|---|-----|
| About You: First, MI, Last Name: | Social Security Number ____ - ____ - ____ | | |
| Address | City | State | Zip |
| Gender: M F | Date of Birth (mm-dd-yy): ____ - ____ - ____ | Phone: () - - - | |
| Email Address: | Are you married or do you have a spouse? Yes No | Date of marriage/union: ____ - ____ - ____ | |
| | Do you have children or other dependents? Yes No | Placement date of adopted child: ____ - ____ - ____ | |

| | | |
|---|--|------------------|
| About Your Job: | Hours worked per week: _____ | Job Title: _____ |
| Work Status: Active Retired Cobra/State Continuation | Date of full time hire: ____ - ____ - ____ | |

About Your Family: Please include the names of the dependents you wish to enroll for coverage. A dependent is a person who relies on you for financial support; and for whom you qualify for a dependent tax exemption. Dependent tax exemptions are subject to IRS rules and regulations. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.

| | | | |
|-------------------------------|------------------|--|---|
| Spouse (First, MI, Last Name) | Gender M F | Social Security Number ____ - ____ - ____ | |
| Address/City/State/Zip: | | Date of Birth (mm-dd-yyyy) ____ - ____ - ____ | |
| Phone: () - - - | | | |
| Child/Dependent 1: | Add Drop | Gender M F | Social Security Number ____ - ____ - ____ |
| Address/City/State/Zip: | | | Date of Birth (mm-dd-yyyy) ____ - ____ - ____ |
| Phone: () - - - | | | Status (check all that apply) Student (post high school) Disabled Non standard dependent |
| Child/Dependent 2: | Add Drop | Gender M F | Social Security Number ____ - ____ - ____ |
| Address/City/State/Zip: | | | Date of Birth (mm-dd-yyyy) ____ - ____ - ____ |
| Phone: () - - - | | | Status (check all that apply) Student (post high school) Disabled Non standard dependent |

CEF2016-NY

Questions? Call the Guardian Helpline (888) 600-1600

www.guardianlife.com

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DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

DATE FORM PUBLISHED: Sep 10, 2018

| | | | | |
|---|-------------|------------------|--|---|
| Child/Dependent 3: Address/City/State/Zip: Phone: () - - | Add Drop | Gender M F | Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____ | Status (check all that apply) Student (post high school) Disabled Non standard dependent |
| Child/Dependent 4: Address/City/State/Zip: Phone: () - - | Add Drop | Gender M F | Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____ | Status (check all that apply) Student (post high school) Disabled Non standard dependent |

| | | |
|--|---------------|-----------------------------------|
| Vision Coverage: You must be enrolled to cover your dependents. Check only one box. | | |
| Your Bi-weekly Premium | Employee Only | EE, Spouse & Dependent/Child(ren) |
| Option 1: VSP | \$5.47 | \$11.75 |
| Option 2: Davis Vision | \$4.78 | \$10.28 |

| |
|--|
| <p>Signature</p> <p>An employee's decision to elect Vision or not elect Vision must be retained until the next plan's Open Enrollment period. If the employee elects not to enroll in vision coverage, they are not eligible to enroll until the plan's next Open Enrollment period.</p> <p>I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.</p> <p>I understand that the premium amounts shown above are estimations and are for illustrative purposes only.</p> <p>Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet.</p> <p>If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person's insurability. Guardian or its designee has the right to reject your request.</p> <p>Plan design limitations and exclusions may apply. For complete details of coverage, please refer to your benefit booklet. State limitations may apply.</p> <p>I hereby apply for the group benefit(s) that I have chosen above.</p> <p>I understand that I must meet eligibility requirements for all coverages that I have chosen above.</p> <p>I agree that my employer may deduct premiums from my pay if they are required for the coverage I have chosen above.</p> <p>I agree that my [employer] or my employer's designated administrator may deduct premiums from my pay apply premiums to my credit card or debit card add premiums to my dues withdraw premiums from my designated bank account, apply premiums to my credit or debit card if they are required for the coverage I have chosen.</p> <p>I acknowledge and consent to receiving electronic copies of insurance related documents, in lieu of paper copies, to the extent permitted by applicable law I voluntarily agree to that arrangement. I do not agree to that arrangement. I understand that I may change my election by providing Guardian 30 day prior written notice.</p> <p>I state that the information provided above is true and correct to the best of my knowledge.</p> <p>Any person who with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially, false information, or conceals for purpose of misleading information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil Penalties, or denial of insurance benefits (Does not apply to Life Insurance).</p> <p>The laws of New York require the following statement appear: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (Does not apply to Life Insurance.)</p> |
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READ YOUR CERTIFICATE CAREFULLY, CERTAIN WAR RISKS ARE NOT ASSUMED. IN CASE OF ANY DOUBT, CONTACT YOUR COMPANY FOR FURTHER EXPLANATION.

The following section applies to these coverage(s): Accident Coverage, Specified Disease Coverage, Hospital Indemnity Coverage:

NOTICE TO CONSUMER: THIS COVERAGE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

SIGNATURE OF EMPLOYEE X _____

DATE _____

Enrollment Kit 00553739, 0001, EN

Fraud Warning Statements

The laws of several states require the following statements to appear on the enrollment form:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection California law requires the following to appear on this form: The falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Connecticut, Iowa, Nebraska, and Oregon: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a fraudulent insurance act, which may be a crime, and may also be subject to civil penalties.

Delaware, Indiana and Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kansas: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud as determined by a court of law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana and Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland : Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Rhode Island: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. § 638:20

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment or a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties or denial of insurance benefits.

Ohio: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.