Plan Type: Dental PPO Plan Network Name: Dental Guard Preferred		Guardian Dental Plan In-Network	 Out-Of-Network
PLAN FEATURES		**Member Expenses**	**Member Expenses**
Calendar Year Deductible	Per Member	$0	$50
	Family Maximum	$0	$150
Preventive Services		Covered 100%	Covered 100%
Basic Services		10%	20% (after deductible)
Major Services (12 month waiting period applies**)		40%	50% (after deductible)
Dental Calendar Year Maximum		$1,500*	$1,000*
Orthodontia (24 month waiting period applies**)		40%	50%
Orthodontia Lifetime Maximum		$1,500*	$1,000*

* All PPO and Non-PPO benefit maximums are combined.
**The waiting periods can be waived with proof of prior dental coverage

Plan Type: Vision PPO Plan Network Name: Access	EyeMed Vision Plan In-Network	 Out-Of-Network*
PLAN FEATURES	**Member Expenses**	**Member Expenses**
Examination with Dilation [a]	$10 co-pay	$35 reimbursement max
Single Vision Lenses [a]	$10 co-pay	$25 reimbursement max
Bifocal Lenses [a]	$10 co-pay	$40 reimbursement max
Trifocal Lenses [a]	$10 co-pay	$55 reimbursement max
Frames [b]	$100 allowance plus 20% off charges over $100	$50 reimbursement max
Standard Contact Lens Fit & Follow Up [d]	$55 maximum member cost	NA
Premium Contact Lens Fit & Follow Up [e]	10% off retail price	NA
Lens UV Coating [a]	$15 additional co-pay [c]	NA
Lens Tint (Solid & Gradient) [a]	$15 additional co-pay [c]	NA
Standard Scratch Resistance Lens [a]	$15 additional co-pay [c]	NA
Standard Polycarbonate Lens [a]	$40 additional co-pay [c]	NA
Standard Anti-Reflective Lens [a]	$45 additional co-pay [c]	NA
Standard Progressive Lens (add-on to Bifocal) [a]	$75 additional co-pay [c]	$40 reimbursement max
Premium Progressive Lens (add-on to Bifocal) [a]	$75 additional co-pay [c], 80% of charge less $120 allowance	$40 reimbursement max
Other Lens Add-Ons and Services [a]	20% discount	NA
Conventional Contact Lenses (materials only) [a]	$115 allowance plus 15% off charges over $115	$92 reimbursement max
Disposable Contact Lenses (materials only) [a]	$115 allowance	$92 reimbursement max
Medically Necessary Contact Lenses [a]	Paid in full	$200 reimbursement max
LASIK or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	N/A

*Pursuant to Texas law, discounts may not be available at all network providers. Prior to your appointment, you should confirm with your provider that discounts are offered.
a. Examinations and lenses OR contacts are covered once every 12 months.
b. Frames are covered once every 24 months.
c. In addition to standard lens co-pay
d. Standard Contact Lens Fitting – spherical clear contact lenses in conventional wear and planned replacement (includes but is not limited to disposable, frequent replacement, etc.)
e. Premium Contact Lens Fitting – all lens designs, material and specialty fittings other than Standard Contact Lenses (includes toric, multifocal, etc.)