Summary of Benefits

Dental Benefit Summary

Group ID:	00443854	**Coverage Type:**	Voluntary
Group Name:	COMMISSION ON ECON OMIC OPPORTU NITY FOR THE GREATER CAPITAL R	**Class:**	0001 ALL OTHER ELIGIBLE EMPLOYEES
Waiting Period:	1st of the month following 30 day(s)	**As of Date:**	02/21/2019

Plan Information

Your dental networks is: Dental - DentalGuard Pref NAP - Syracuse

Coverage Information

	Dental - DentalGuard Pref NAP - Syracuse	
What's the most cost-effective way to use dental insurance?	You may go to any dentist, however those who belong to the **Dental - DentalGuard Pref NAP - Syracuse** network will be most cost effective.	
	In Network	Out of Network
Calendar year deductible	Out of Network is a combined deductible for in and out of network services.	$50, Once the annual deductible is met by each of three family members, no further deductibles apply.
Preventive		Waived
Basic		Not Waived
Major		Not Waived
Calendar Year Maximum Benefit	The amount shown in the out of network field is your combined Calendar Year maximum for both in and out of network services.	$2,000
Lifetime Orthodontia Maximum	The amount shown in the out of network field is your combined Lifetime Orthodontia Maximum for both in and out of network services	$1,250
Maximum rollover	Yes	Yes
Monthly Switch	Not Available	Not Available
	How much does the plan pay?	How much does the plan pay?
Office Visit Co-pay (one office visit may cover multiple services)	None	None
Preventive Care:	90%	90%

	Dental - DentalGuard Pref NAP - Syracuse	
What's the most cost-effective way to use dental insurance?	You may go to any dentist, however those who belong to the **Dental - DentalGuard Pref NAP - Syracuse** network will be most cost effective.	
	In Network	Out of Network
Bitewing X-Rays	90%	90%
Full Mouth X-Rays	90%	90%
Cleaning	90%	90%
Oral Exams	90%	90%
Sealants (per tooth)	90%	90%
Basic Care:	80%	80%
Fillings (one surface)	80%	80%
General Anesthesia[1]	80%	80%
Scaling & Root Planing (per quadrant)	80%	80%
Simple Extractions	80%	80%
Major Care:	50%	50%
Dentures	50%	50%
Single Crowns	50%	50%
Orthodontia	50%	50%

General Exclusions

Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred PPO plans:

This policy provides dental insurance only. Coverage is limited to charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury.

Deductibles apply.

The plan does not pay for:

- Oral hygiene services (except as covered under preventive services),
- Orthodontia (unless expressly provided for),
- Cosmetic or experimental treatments (unless they are expressly provided for).
- Any treatments to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment.

The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic, and prosthodontic services. 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-DEN -16 et al.

Teeth lost or missing before a covered person becomes insured by this plan. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he became insured by this plan. We won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan. R3-DG2000

1 Restrictions apply and may be subject to medical necessity.

This Benefit Summary is for illustrative purposes. Your benefits booklet will show exactly what is covered and/or excluded under your plan. If there is a discrepancy between this Benefit Summary and your benefit booklet, the benefit booklet prevails.

Definitions shown on this site are in summary form and are for general informational purposes. The terms of the insurance contract prevails.

Guardian

Summary of Benefits

Vision Benefit Summary

Group ID:	00443854	**Coverage Type:**	Voluntary
Group Name:	COMMISSION ON ECONOMIC OPPORTU NITY FOR THE GREATER CAPITAL R	**Class:**	0001 ALL OTHER ELIGIBLE EMPLOYEES
		As of Date:	02/21/2019
Waiting Period:	1st of the month following 30 day(s)		

Plan Information

Your network is the Davis - Full Feature - Designer

Coverage Information

	Davis - Full Feature - Designer	
What's the most cost-effective way to use vision benefits?	You may go to any eye doctor however, if you go to a Davis Vision network provider you will usually pay less.	
	In-Network	**Out-Of-Network**
Co-Pay		
First service provided	Not applicable	
Exams	Exams $10.00	
Materials	waived for non-formulary elective contact lenses $10.00	
How often can I obtain service?	**Exams:** Every 12 months **Lenses:** Every 12 months **Frames:** Every 24 months **Materials:** Every 12 months	
	In-Network	**Out-Of-Network**
Eye exams	Copay applies	Amount over: $46.00
Lenses		
Single vision lenses	Copay applies	Amount over: $47.00

	Davis - Full Feature - Designer	
What's the most cost-effective way to use vision benefits?	You may go to any eye doctor however, if you go to a Davis Vision network provider you will usually pay less.	
	In-Network	**Out-Of-Network**
Lined bifocal lenses	Copay applies	Amount over: $66.00
Lined trifocal lenses	Copay applies	Amount over: $85.00
Lenticular lenses	Copay applies	Amount over: $125.00
Contact Lenses		
Conventional	$135.00, 15% discount on amount over $135.00.	Amount over: $105.00
Planned replacement and disposable	$135.00, 15% discount on amount over $135.00.	Amount Over $105.00
Medically necessary	Covered in full with prior approval. Copay does not apply.	Amount over: $210.00
Evaluation and fitting	15% off professional fee [1]	Included in Elective Contact Lens allowance
Frames	$135.00, 20% discount on amount over $135.00, except Sam's Club/Walmart. [2]	Amount over: $47.00
Lens & Frame Allowance	No discounts	No discounts
Cosmetic Extras	No additional charge for: Oversize lens, polycarbonate for kids, polycarbonate for adults with strong prescriptions [3], tinting. Others discounted at 20%-50% off retail price.	No discounts
Laser correction surgery	Up to 25% off usual and customary.	No discounts
Hearing	No discounts	No discounts

Vision and General Exclusions

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;
- 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-DAVIS-05-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.

1 If contact lenses from formulary are chosen, then evaluation and fit may be included. When contact lenses not in the Formulary are chosen and the evaluation, fit and lenses are supplied by the same vision provider at the same time, all can be applied to the elective contact lens allowance.

2 Frames from Davis Vision's Fashion, Designer, or Premier collections are covered in full in excess of the plan's materials copay. Frames from a Davis Vision network provider that are not in the collections are covered up to the plan's retail allowance in excess of the plan's materials copay.

3 Polycarbonate lenses covered in full for monocular patients and patients with prescriptions greater than or equal to +/-6.00 diopters.

At Sam's Club/Wal-Mart Vision Centers, members receive Sam's Club/Wal-Mart's everyday low price on frame and contact lenses purchases. For eyeglass lens purchases the member receives the lesser of Sam's Club/Wal-Mart's everyday low price or the Davis Vision fixed charge.

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