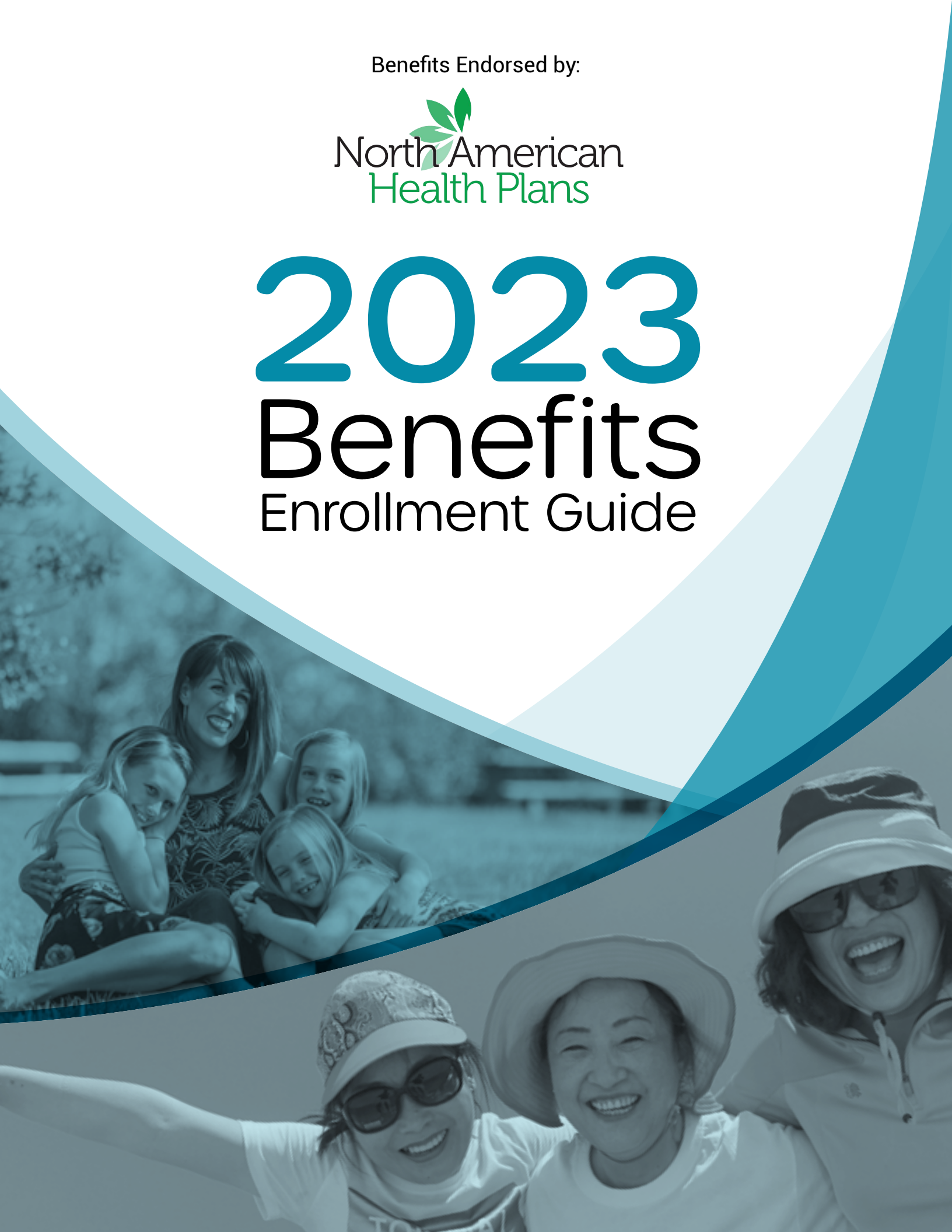
Benefits Endorsed by:

North American Health Plans

2023 Benefits Enrollment Guide



Coverage Made Easy

America's Consumers and Affiliates Benefits

The America's Consumers & Affiliates Limited Partnership provides an opportunity for partners to earn a secondary income through use of the Legend Browser application and to receive access to a comprehensive health and life benefits package. The Legend Browser offers a way for partners to rate websites or click on advertisements while browsing the Internet to earn a passive income. Using the Legend Browser when browsing the Internet an annual average of 10 hours per week makes you an active limited partner to maintain eligibility for benefits.

Becoming an active partner is easy!

1. Download the Legend Browser application on a phone/tablet and/or extension on your Chrome or Firefox browser.
2. **Log in with your Partner Identification Number (PIN)** provided by the Limited Partnership
3. **Use the Legend Browser** to explore the Internet, rate the websites you visit, and take advantage of the advertisements offered to earn passive income.

By joining the AC&A Limited Partnership and becoming an active partner, individuals are eligible to receive established Voluntary Insurance Benefits with National "A" Rated insurance carriers, in which you and your family may participate. If a partner should later choose he no longer wishes to participate in the Limited Partnership income earning opportunities, he may choose to keep his coverage with any of the portable benefits offered. See the LP Benefit Guide for notations of portable products.

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America's Consumers & Affiliates

SelectMed

Medical Options

SelectMed

	SelectMed Base	SelectMed Pro	SelectMed Max
Evidence of insurability	**Guaranteed Acceptance**	**Guaranteed Acceptance**	**Guaranteed Acceptance**
PPO Network		First Health®	
Deductible	**In-Network Provider (No Out of Network Coverage)**	**In-Network Provider (No Out of Network Coverage)**	**In-Network Provider (No Out of Network Coverage)**
Individual	n/a	n/a	$2,000
Family	n/a	n/a	$4,000
Out-of-Pocket Maximum	**In-Network Provider (No Out of Network Coverage)**	**In-Network Provider (No Out of Network Coverage)**	**In-Network Provider (No Out of Network Coverage)**
Individual	n/a	$9,100	$9,100
Family	n/a	$18,200	$18,200
SelectMed Medical Services	**In-Network Provider (No Out of Network Coverage)**	**In-Network Provider (No Out of Network Coverage)**	**In-Network Provider (No Out of Network Coverage)**
MedCall Now	Included (No Copay)	Included (No Copay)	Included (No Copay)
Personal Assistance Counseling	Not Covered	Confidential counseling assistance to help balance the demands of work, family, and daily life. $0 up to 6 visits per unique issue per year via telephone, video, or chat	
Preventative & Wellness* (Non-Hospital Based)	100% Covered in Network-No copay and No deductibles.		
Primary Care Visit to Treat Injury or Illness (Non-Hospital Based)	Not Covered	$25.00 Copay Max 5 Visits Per Calendar Year; Combined 5 Visit Limit Per Year	$25.00 Copay per visit
Specialist Visit (Non-Hospital Based)			$50.00 Copay per visit
Outpatient Diagnostic Test (X-Ray, Blood Work) (Non-Hospital Based)			$50.00 Copay per test
Urgent Care			$50.00 Copay per visit
Outpatient CT/MRI /Pet Scans		Not Covered	50% Coinsurance per test; After Deductible.[2]
Outpatient Services: Mental Health, Behavioral Health or Substance Abuse Services			$50.00 Copay per visit *(Partial Hospitalization is not covered; Considered a Specialist Visit)*
Rehabilitation Services & Habilitation Services (Physical, Speech, and Occupational)			$50 copay/visit: *(Physical, Speech, and Occupational; Limited to 20 visits per plan year. Pre-certification is required after 6 visits)*
PHARMACY BENEFITS - Included in SelectMed			
Preventive Prescriptions	No Copay for ACA Compliant covered prescription drugs		
Non-Preventive Prescriptions	Not Covered	20% Coinsurance - Generic Only 12 Prescriptions Maximum 30 day supply Maximum	$20 Copay - Generic only 30 day supply Maximum
PHARMACY BENEFITS - Provided by DataRX[2]			
Prescription Benefit	Not Covered	Not Covered	Copay: $10 Formulary Generic; $50 Formulary Brand Mail Copay: $30 Formulary Generic; $150 Formulary Brand Annual Max: $750 Per Person; $1500 Per Family [1]
Monthly Rates			
Individual	$84.78	$131.17	$207.25
Individual + Spouse	$139.69	$199.53	$346.11
Individual + Child	$130.12	$192.43	$354.87
Family	$184.03	$254.71	$516.17

Not available in Alaska, Hawaii, Massachusetts, and New Hampshire.
Insurance coverage is provided through Providence Insurance Company, LLC.
1. Prescription Benefit is a subcontracted plan managed by your enrollment agency and is not part of the health plan design. The prescription provided by DataRx is not available in NY, SD, and WA. In the states noted, $20 co-pay generic only, 30 day supply max.
2. Pre-Authorization Required
For additional information, visit: https://www.healthcare.gov/coverage/preventive-care-benefits/ as benefits are subject to change. Or reference the Summary Plan Document for a list of Wellness & Preventative services offered In-Network.
First Health is a brand name of First Health Group Corp., an indirect, wholly-owned subsidiary of Aetna Inc.
Refer to the schedule of benefits for a more in-depth list of Benefits Coverage, Limitations and Exclusions. If this document differs from the Schedule of Benefits, the Schedule of Benefits will govern.

Hospitalization Buy-Up for SelectMed Pro and Max Plans

The More You Know

This Plan covers limited inpatient hospital care in accredited hospitals for each enrolled participant. Coverage includes inpatient surgery, but not outpatient or elective surgeries. This Plan does not cover out of network services. This Plan is not subject to the Patient Protection and Affordable Care Act.

Hospitalization Buy-Up to SelectMed Pro/Max Plans	
Evidence of insurability	Guaranteed Acceptance
Annual Plan Year Limit	Choose $50,000 or $100,000 Per Participant
Participant Coinsurance	0%
TPA	HMA, LLC
PPO Network	First Health Network
Network Coverage	In-Network Only
Plan Provisions	Participating Providers (No Out-of-Network Providers)
Inpatient Hospital Benefits including MHSA (Mental Health and Substance Abuse)	$5,000 Deductible, then 0% Coinsurance
Limitations & Exclusions	Outpatient or elective surgery not covered. Pre-existing conditions within past twelve months excluded.

Monthly Rates				
$50,000 Plan	**Primary**	**Primary + Spouse**	**Primary + Child(ren)**	**Family**
Ages 18-34	$87.00	$131.00	$135.00	$195.00
Ages 35 - 64	$117.00	$193.00	$189.00	$279.00
$100,000 Plan	**Primary**	**Primary + Spouse**	**Primary + Child(ren)**	**Family**
Ages 18-34	$122.95	$217.08	$199.97	$294.10
Ages 35 - 64	$151.18	$276.78	$253.95	$379.54

The Hospitalization buy-up plan is available for purchase with SelectMed Pro or SelectMed Max.

This coverage is available when you join the Limited Partnership. Partners must be active to maintain eligibility.

SelectMed Metallic Plan Options

SelectMed Metallic Plan Options	SelectMed Bronze	SelectMed Silver
Evidence of insurability	**Guaranteed Acceptance**	**Guaranteed Acceptance**
PPO Network	PHCS Practitioner and Ancillary **(No Out of Network Coverage)**	
Deductible	**In Network Participating Providers**	**In Network Participating Providers**
Individual	$0	$0
Family	$0	$0
Out-of-Pocket Maximum	**In Network Participating Providers**	**In Network Participating Providers**
Individual	$9,100	$5,000
Family	$18,200	$10,000
Medical Services		
PREVENTIVE & WELLNESS SERVICES	**In Network Participating Providers (No Out of Network Coverage)**	**In Network Participating Providers (No Out of Network Coverage)**
Non-Hospital Based Only	$0 Copay *(Plan pays 100% of covered preventive and wellness services)*	
PHYSICIAN SERVICES	**In Network Participating Providers (No Out of Network Coverage)**	**In Network Participating Providers (No Out of Network Coverage)**
Primary Care Office Visit (Non-Hospital Based)	$25 Copay *(Limited to 8 visits per calendar year)*	$15 Copay *(Limited to 10 visits per calendar year)*
Specialist Office Visit (Non-Hospital Based)	$50 Copay *(Limited to 8 visits per calendar year)*	$25 Copay *(Limited to 10 visits per calendar year)*
Other Physician Services performed in the Office[1,2]	Not Covered	$50 Copay per service billed *(Limited to Primary Care/Specialist visits per plan year)*
Urgent Care	$50 Copay *(Limited to 2 visits per calendar year)*	$35 Copay *(Limited to 3 visits per calendar year)*
Telemedicine Services	$0 Copay	$0 Copay
Personal Assistance Counseling	Confidential counseling assistance to help balance the demands of work, family, and daily life. $0 copay up to 6 visits per unique issue per year via telephone, video, or chat	
DIAGNOSTIC SERVICES	**In Network Participating Providers (No Out of Network Coverage)**	**In Network Participating Providers (No Out of Network Coverage)**
Laboratory Services (Non-Hospital Based)	$50 Copay *(Combined limit of 3 visits per calendar year with Radiology)*	
Radiology (Non-Hospital Based)	$50 Copay *(Combined limit of 3 visits per calendar year with Laboratory Services)*	
CT/MRI/MRA/PET Scan[1] (Non-Hospital Based)	$350 Copay *(Subject to RBP)* *(Limited to 1 per calendar year.)*	$350 Copay *(Subject to RBP)* *(Limited to 2 per calendar year.)*
HOSPITAL/FACILITY SERVICES (Copay + Balance Subject to Referenced Based Pricing)		
Inpatient Hospitalization[1]	$350 Copay per admission *(Limited to 5 days per calendar year)*	$350 Copay per admission *(Limited to 7 days per calendar year)*
Inpatient Visits - Physician	Copay Included in Inpatient Hospitalization *(Limited to visits up to 5 days per calendar year)*	Copay Included in Inpatient Hospitalization *(Limited to visits up to 7 days per calendar year)*
Laboratory/Radiology/Imaging	Copay included in Inpatient or Emergency Room Services. *(Limited to 5 days inpatient and 1 visit outpatient and emergency room per calendar year)*	Copay included in Inpatient or Emergency Room Services. *(Limited to 7 days inpatient and 1 visit outpatient and emergency room per calendar year)*
Inpatient Surgery[1]	Copay Included in Inpatient Hospitalization *(Second surgical opinion may be required; Limited to 2 surgeries per calendar year)*	Copay Included in Inpatient Hospitalization *(Second surgical opinion may be required; Limited to 3 surgeries per calendar year)*
Outpatient Hospital or Free Standing Facility Services and Surgery[1]	$350 Copay *(Limited to 1 visit per calendar year)*	$350 Copay *(Limited to 2 visit per calendar year)*
Anesthesia	Copay Included in Inpatient Hospitalization or Outpatient Hospital or Free Standing Facility Services and Surgery *(Limited to 2 inpatient and 1 outpatient anesthetic procedures per calendar year)*	Copay Included in Inpatient Hospitalization or Outpatient Hospital or Free Standing Facility Services and Surgery *(Limited to 3 inpatient and 2 outpatient anesthetic procedures per calendar year)*
Emergency Room Services	$350 Copay *(Limited to 1 visit per calendar year)*	

SelectMed Metallic Plan Options

		SelectMed Bronze	SelectMed Silver
PREGNANCY BENEFITS			
Professional Services		Not Covered - 100% paid by Member	$350 Copay
Childbirth/Delivery (Considered Inpatient Hospital Stay)		Not Covered - 100% paid by Member	$350 Copay per admission *(Subject to RBP)*
OTHER SERVICES			
Allergy Services (Included in Primary Care Office Visit or Specialist Office Visit limits. The copay applies to the administration of the allergy service and is separate from the copay for the office visit)		$25 Copay	
Home Health Care		$25 Copay *(Limited to 10 visits per calendar year)*	$25 Copay *(Limited to 15 visits per calendar year)*
Treatment for Chemical Abuse & Dependency[1]	In-Patient	$250 Copay per day *(Subject to RBP)* *(Limited to 5 days per calendar year)*	$250 Copay per day *(Subject to RBP)* *(Limited to 7 days per calendar year)*
	Out-Patient	$25 Copay per day *(Limited to 5 days per calendar year)*	$25 Copay per day *(Limited to 7 days per calendar year)*
Rehabilitation/Habilitation Services		Not Covered - 100% paid by Member	
Emergency Medical Transportation		$250 Copay *(Subject to RBP)* *(By land only; Limited to 1 transport per calendar year)*	
PHARMACY BENEFITS - Included in SelectMed		**Participating Pharmacies**	
Preventive Prescriptions - (Subject to Formulary)		Generic - $0 Copay *(Limited to Preventive Generic)*	
Non-Preventive Prescriptions - (Subject to Formulary)		Not Covered	
PHARMACY BENEFITS - Provided by DataRX[3]		**Participating Pharmacies**	
Prescription Benefit		Copay: $10 Formulary Generic; $50 Formulary Brand Mail Copay: $30 Formulary Generic; $150 Formulary Brand Annual Max: $750 Per Person; $1500 Per Family[3]	

Monthly Rates	**SelectMed Bronze**	**SelectMed Silver**
Individual	$487.89	$589.48
Individual + Spouse	$853.26	$1,016.37
Individual + Child	$880.90	$1,047.49
Family	$1,308.36	$1,588.64

Not available in Alaska, Hawaii, Massachusetts, and New Hampshire.
Reinsurance coverage is provided through Providence Insurance Company II

1. If prior authorization is not obtained for services requiring a prior authorization, the benefits payable by the Plan for such services will be reduced to 50% of the allowed charges after the copay.
2. Prior authorization is required for any service or procedure over $1,000.
3. Prescription Benefit is a subcontracted plan managed by your enrollment agency and is not part of the health plan design. The prescription provided by DataRx is not available in NY, SD, and WA. For the SelectMed Max plan only: In the states noted, $20 co-pay generic only, 30 day supply max.

If ER and/or Ambulance Services are covered and provided by an Out of Network provider, the service will be subject to the deductible and Out of Pocket Maximum
For additional information, Limitations and Exclusions; please refer to the Summary Plan Document and Schedule of Benefits. If this document differs from either, the Summary Plan Document and Summary of Benefits Coverage will govern.
To find a provider through the PHCS Practitioner and Ancillary: https://www.multiplan.com/webcenter/portal/ProviderSearch

SelectMed Metallic Plan Options

Preventive Health Services: Limitations, Intervals, and Requirements[1]

The following table represents the preventive services currently covered under the SelectMed Bronze and SelectMed Silver™ Plans as well as the permitted interval and any requirements of such preventive services.

Benefits are automatically subject to 29 CFR § 2590.715 -2713(a). Amendments to this section through legislative act or regulation are automatically incorporated into this document by reference. Preventive Services covered in this section are explained in more detail through the following official resources:

- Medical services with a rating of "A" or "B" from the current recommendations of the United States Preventive Services Task Force. See https://www.uspreventiveservicestaskforce.org
- Preventive care and screenings for infants, children, and adolescents provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. Guidelines can be found in https://www.hrsa.gov
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention for certain individuals only. See https://www.cdc.gov/vaccines/acip

Preventative and Wellness Services - Covered Benefits

Adults
- Adult Annual Standard Physical
- Alcohol Misuse: Unhealthy Alcohol Use Screening and Counseling
- Aspirin: Preventive Medication
- Blood pressure screening
- Breastfeeding interventions
- Chlamydia screening
- Colorectal Cancer Screening
- Dental cavities prevention: infants and children up to age 5 years
- Depression Screening
- Diabetes Screening
- Fall Prevention: Older Adults
- Healthy Diet and Physical Activity Counseling to Prevent Cardiovascular Disease
- Hemoglobinopathies screening
- Hepatitis B screening
- Hepatitis C virus (HCV) infection screening: born between 1945 and 1965.
- High Blood Pressure Screening
- HIV Preexposure Prophylaxis for the Prevention of HIV Infection
- HIV Screening
- Hypothyroidism screening
- Lung Cancer Screening
- Obesity screening and Counseling
- Sexually Transmitted Infections Counseling
- Skin Cancer Behavioral Counseling
- Statin Preventive Medication
- Tobacco Use Counseling and Interventions
- Syphilis Screening

Men
- Abdominal aortic aneurysm screening

Women
- Aspirin: Preventive Medication
- BRCA risk assessment and genetic counseling/ testing
- Breast Cancer Preventive Medications
- Breast Cancer Screening
- Cervical Cancer Screening: with Cytology (Pap Smear) Lung cancer screening
- Chlamydia Screening
- Contraceptive Methods and Counseling
- Folic Acid Supplementation
- Gonorrhea Screening
- Intimate Partner Violence Screening
- Osteoporosis Screening
- Well-Woman Visits

Pregnant Women
- Bacteriuria Screening
- Breastfeeding Support, Supplies and Counseling
- Depression Screening
- Gestational Diabetes Mellitus Screening
- Hepatitis B Screening
- HIV Screening
- Preeclampsia Screening
- Rh Incompatibility Screening: First Pregnancy Visit
- RH Incompatibility Screening: 24–28 Weeks' Gestation
- Syphilis Screening
- Tobacco Use Counseling and Interventions

Newborns
- Gonorrhea Prophylactic Medication
- Hemoglobinopathies Screening
- Hypothyroidism Screening
- Phenylketonuria Screening

Infants
- Dental Caries Prevention: Infants and Children Up to Age 5

Children
- Dental Caries Prevention: Infants and Children Up to Age 5
- Obesity screening and Counseling
- Skin Cancer Behavioral Counseling
- Tobacco Use Counseling and Interventions
- Vision Screening: Age 3 to 5
- Well-Child Visits

Adolescents
- Depression Screening
- Hepatitis B Screening
- HIV Screening
- Obesity screening and Counseling
- Sexually Transmitted Infections Counseling
- Skin Cancer Behavioral Counseling
- Tobacco Use Counseling and Interventions

Multiple Populations
- Tuberculosis Screening: all populations at risk
- Skin Cancer Behavioral Counseling: young adults, adolescents, children, and parents of young children

***See Schedule of Benefits for Limitations, Intervals and Requirements.**

Vaccines

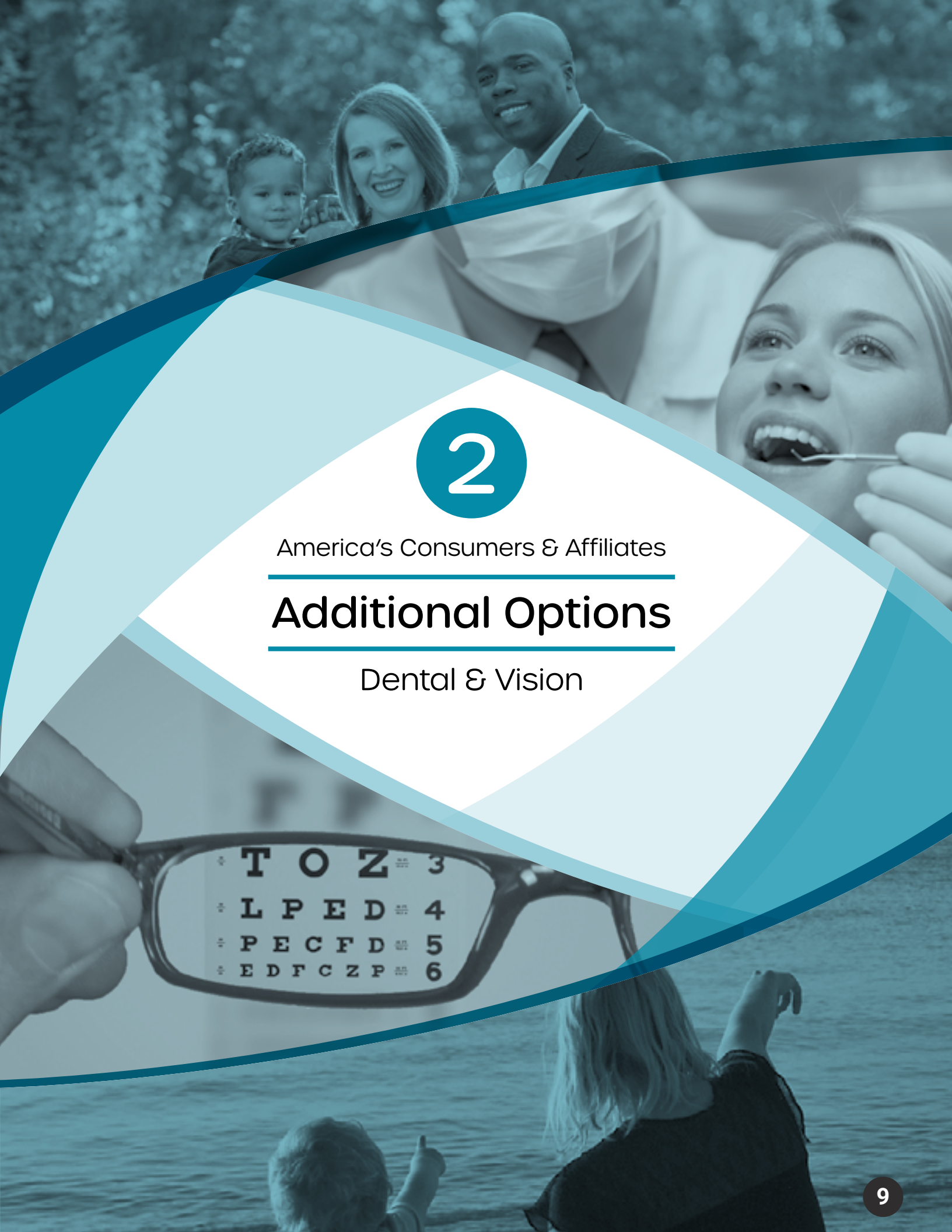
IMMUNIZATIONS - recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention for routine use in children, adolescents, or adults*

Adults 19 Years or Older	Children From 7 Through 18 Years Old	Birth Through 6 Years Old
• IIV • RIV • LAIV • Tdap • MMR • VAR • RZV • ZVL • HPV - Female • HPV- Male • PCV13 • PPSV23	• Flu • Tdap • HPV • MenACWY • MenACWY	• HepB • DTaP • Hib • PCV13 • IPV • Flu • MMR • VAR • HepA • RV

1. None of the Preventive Health Services are covered if they are provided at a hospital.

* Immunization illustrations listed herein are based upon CDC recommendations contained in the following schedules: (i) Recommended Child and Adolescent Immunization Schedule (available at: https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html), and (ii) Recommended Adult Immunization Schedule (available at: https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html). Additional immunization scenarios not included in the aforementioned illustrations (such as catch-up immunization recommendations, immunization recommendations for certain high-risk groups, and immunization recommendations subject to individual clinical decision-making) may also be covered under this Plan pursuant to CDC recommendation. Information concerning these additional covered immunization scenarios (including vaccine type, age requirements, and frequency) is available online under the CDC schedule links listed above. Paper copies of these CDC schedules can also be obtained free of charge by written request to the Plan Administrator.

This plan is ACA Compliant. For additional information, visit: https://www.healthcare.gov/coverage/preventive-care-benefits/ as benefits are subject to change. Or reference the Summary Plan Document for a list of Wellness & Preventative services offered In-Network.



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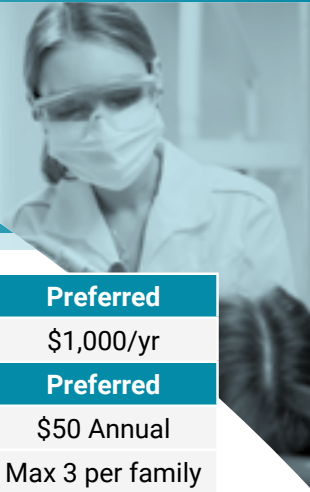
America's Consumers & Affiliates

Additional Options

Dental & Vision

Dental Insurance



Plan Maxes		Basic	Preferred
Annual Maximum		$500/yr	$1,000/yr
Plan Deductible		**Basic**	**Preferred**
Deductible		$50 Annual	$50 Annual
Deductible Limit		Max 3 per family	Max 3 per family
Services*	**Plan Coverage**	**Basic**	**Preferred**
Preventive Services	• Cleanings • Exams • Oral Cancer Screening (age 40+) • Radiographs - Bitewings • Radiographs - FMX • Fluoride (under age 16) • Sealants (under age 16) • Space Maintainers (under age 16)	Plan Pays 100% Deductible Waived	Plan Pays 100% Deductible Waived
Basic Services	• Emergency Pain • Restorations (Amalgams & Anterior Resin) • Restorations (Posterior Resin) • Crown Repairs • Bridge Repairs • Denture Repairs	Plan Pays 80%	Plan Pays 80%
Major Services[1]	• Simple Extractions • Surgical Extractions • Oral Surgery • Endodontics • Periodontal Maintenance • Non-Surgical Periodontics • Surgical Periodontics • Inlays • Onlays • Crowns • Bridges • Dentures • Implants • Anesthesia	Plan Pays 0%	Plan Pays 50%

Plan Tier	Primary	Primary + Spouse	Primary + Child(ren)	Family
Basic	$19.67/mo	$35.34/mo	$43.31/mo	$63.33/mo
Preferred	$27.98/mo	$51.94/mo	$54.52/mo	$83.40/mo

1. 12 month waiting period on Major services

Underwritten by National Guardian Life Insurance Company. National Guardian Life Insurance Company is not affiliated with the Guardian Life Insurance Company of America, a/k/a The Guardian or Guardian Life. | | DENTPROP20

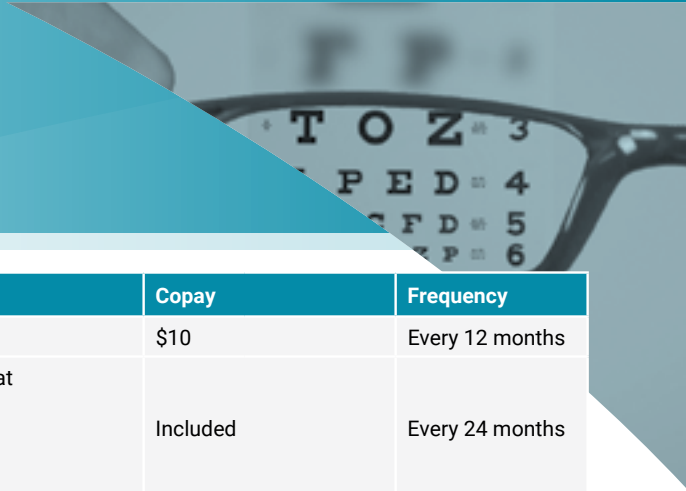
The information on this sheet is a brief summary of your dental plan and the services it covers. There are some limitations on the expenses for which your dental plan pays. If you have specific questions regarding benefit coverage, limitations, exclusions, or non-covered services, please refer to your certificate of coverage/dental benefit booklet or contact BrightBenefits.

Eligible partners must be working a minimum of 20 hours per week to qualify for insurance. Rates include insurance premiums and administrative fees for continuation, enrollment and marketing.

This coverage is available when you join the Limited Partnership. Partners must be active to maintain eligibility.

DENTPROP20

Vision Insurance



Benefit	Description	Copay	Frequency
Eye Exam	Focuses on your eyes, vision and wellness	$10	Every 12 months
Frame	Pay no more than $25 for Exclusive Collection frames at participating locations or $130 frame allowance at network locations or $180 frame allowance at Visionworks [1] Plus 20% off any amount over your allowance [2]	Included	Every 24 months
Lenses and enhancements[3]	Clear plastic single -vision, bifocal, trifocal or lenticular lenses Polycarbonate Lenses for dependent children Tinting of Plastic Lenses Scratch-Resistant Coating	$25	Every 12 months
Lens upgrades[3]	Polycarbonate lenses for adults	$30	Every 12 months
	High-Index Lenses 1.67	$55	
	High-Index Lenses 1.74	$120	
	Polarized Lenses	$75	
	Progressive Lenses (Standard / Premium / Ultra / Ultimate)	$50 / $90 / $140 / $175	
	Anti-Reflective (AR) Coating (Standard / Premium / Ultra / Ultimate)	$35 / $48 / $60 / $85	
	Ultraviolet Coating	$12	
	Plastic Photochromic Lenses (Transitions® Signature™)	$65	
	Premium Scratch -Resistant Coating	$30	
	Scratch-Protection Plan (Single -Vision / Multifocal)	$20 / $40	
	Digital Single Vision Lenses	$30	
	Trivex Lenses	$50	
	Blue Light Filtering	$15	
Prescription contacts [4] (instead of glasses)	15% off fitting, evaluation and follow-up $130 allowance for contacts Plus 15% off any amount over your allowance[2]		Every 12 months

Extra member savings (not insured benefits)

- 15% off standard laser vision correction or 5% off promotional prices at LasikPlus® locations nationwide.
- No more than $39 on routine retinal imaging as an enhancement to an eye exam .
- 30% off additional pairs of eye glasses.[2]
- Free 1-yr. breakage warranty on your glasses - limitations apply.

Out-of-network coverage

Exam.....$40	Single vision lenses.....$40	Trifocal lenses.....$80	Elective contacts.....$105
Frame.....$50	Bifocal/Progressive lenses.....$60	Lenticular lenses.....$100	Visually required contacts....$225

Vision Rates			
Primary	Primary + Spouse	Primary + Child(ren)	Family
$10.22/mo	$16.76/mo	$18.42/mo	$25.22/mo

1. Excludes Maui Jim® eyewear.
2. Some limitations apply to additional discounts; discounts not applicable at all in-network providers.
3. Spectacle lens options may not be available at all locations.
4. Contact lens coverage varies by product selection. Visually Required contacts are covered in full with prior approval. Davis Vision has done its best to accurately reflect plan coverage herein. If differences exist between this document and the plan contract, the contract will prevail. Products may vary by state.

Underwritten by National Guardian Life Insurance Company. National Guardian Life Insurance is not affiliated with the Guardian Life Insurance Company of America, a/k/a The Guardian or Guardian Life.

Eligible partners must be working a minimum of 20 hours per week to qualify for insurance. Rates include insurance premiums and administrative fees for continuation, enrollment and marketing.

This coverage is available when you join the Limited Partnership. Partners must be active to maintain eligibility.

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