Charles A. Beard Memorial School Corporation
Knightstown, Indiana

2022 Dental & Vision Benefits Snapshot & Election Form

Dental Insurance	Guardian Dental Plan 1	Guardian Dental Plan 2
	In-Network	In-Network
Deductible: Individual/Family	$50 / $150	$75 / $225
Annual Maximum Benefit: Per Individual	$1000 Per Calendar Year	$1000 Per Calendar Year
Preventive & Diagnostic Services	80%	100%
Basic Dental Services	80%	80%
Major Dental Services	50%	50%
Orthodontia	50%	50%
Orthodontia Lifetime Maximum: Per Individual	$1000 Ortho applies to child only (up to age 19)	$1000 Ortho applies to child only (up to age 19)
Dependent Age Limit	26	26
Plan Enrollment Options & Monthly Cost: **Please check one:**	☐ **-Employee Only: $30.59** ☐ **-Employee / Spouse: $60.88** ☐ **-Employee / Children: $76.00** ☐ **-Family: $104.51** ☐ **-Waive**	☐ **-Employee Only: $36.21** ☐ **-Employee / Spouse: $72.07** ☐ **-Employee / Children: $92.23** ☐ **-Family: $126.32** ☐ **-Waive**

Vision Insurance	Guardian Avesis Vision Plan 1		Guardian VSP Vision Plan 2	
	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Comprehensive Vision Exam	$10		$10	
Frequencies – Based on last date of service	Exam: 12 Months Lenses: 12 Months Frames: 24 Months Contacts: 12 Months		Exam: 12 Months Lenses: 12 Months Frames: 24 Months Contacts: 12 Months	
Pair of Lenses Standard Single Vision Standard Lined Bifocal Standard Lined Trifocal	 $20 $20 $20	 $30 Allowance $50 Allowance $65 Allowance	 $20 $20 $20	 $23 Allowance $37 Allowance $49 Allowance
Frames	$130 Allowance, then 20% off remaining balance	$70 Allowance	$130 Allowance, then 20% off remaining balance	$46 Allowance
Contact Lenses Non-Elective Contact Lens	 $130 Allowance	 $120 Allowance	 $130 Allowance	 $100 Allowance
Plan Enrollment Options & Monthly Cost: **Please check one:**	☐ **-Employee Only: $10.08** ☐ **-Employee / Spouse: $19.18** ☐ **-Employee / Children: $17.67** ☐ **-Family: $29.29** ☐ **-Waive**		☐ **-Employee Only: $11.49** ☐ **-Employee / Spouse: $21.87** ☐ **-Employee / Children: $20.14** ☐ **-Family: $33.39** ☐ **-Waive**	

My signature below confirms my Plan enrollment choice(s), if any, and authorizes my employer to deduct the premium for the selected plan(s) from each of my payrolls (24 deductions or 18 deductions).

If I have declined coverage, I understand that I am not eligible to participate in the Group Dental and/or Vision Plans again until the annual Open Enrollment period, unless I have a COBRA qualifying event or change in qualifying status.

Employee Name Printed: _____ Employee Signature: _____ Date: _____