About Your Benefits:

A visit to your dentist can help you keep a great smile and prevent many health issues. But dental care can be costly and you can be faced with unforeseen expenses. Did you know, a crown can cost as much as $1,400\(^1\)? Guardian dental insurance will help you pay for it. With access to one of the largest network of dental providers in the country, who agreed to charge negotiated fees for their services of up to 30% less than average charges in the same community, you will benefit from lower out-of-pocket costs, quality care from screened and reviewed dentist, no claim forms to file, and excellent customer service. Enroll today and smile next time you see your dentist!

\(^1\)http://health.costhelper.com/dental-crown.html.

**Option 1:** With your **Plan A - Base Plan** plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist. Out-of-network benefits are limited to our PPO fee schedule.

**Option 2:** With your **Plan B- Dr not Par** plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist.

### Your Dental Plan

<table>
<thead>
<tr>
<th>Your Network is</th>
<th>Option 1: Plan A - Base Plan</th>
<th>Option 2: Plan B- Dr not Par</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Dental Plan</td>
<td>DentalGuard Preferred</td>
<td>DentalGuard Preferred</td>
</tr>
<tr>
<td>Calendar year deductible</td>
<td>In-Network $100, Out-of-Network $100</td>
<td>In-Network $100, Out-of-Network $100</td>
</tr>
<tr>
<td>Family limit</td>
<td>Preventive 3 per family</td>
<td>Preventive 3 per family</td>
</tr>
<tr>
<td>Charges covered for you (co-insurance)</td>
<td>In-Network 100%, Out-of-Network 100%</td>
<td>In-Network 100%, Out-of-Network 100%</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Basic Care</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Major Care</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Orthodontia</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Annual Maximum Benefit</td>
<td>$1000</td>
<td>$1000</td>
</tr>
<tr>
<td>Maximum Rollover</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Rollover Threshold</td>
<td>$500</td>
<td>$500</td>
</tr>
<tr>
<td>Rollover Amount</td>
<td>$250</td>
<td>$250</td>
</tr>
<tr>
<td>Rollover In-network Amount</td>
<td>$350</td>
<td>$350</td>
</tr>
<tr>
<td>Rollover Account Limit</td>
<td>$1000</td>
<td>$1000</td>
</tr>
<tr>
<td>Lifetime Orthodontia Maximum</td>
<td>$1000</td>
<td>$1000</td>
</tr>
<tr>
<td>Dependent Age Limits (Non-Student/Student)</td>
<td>19/23</td>
<td>19/23</td>
</tr>
</tbody>
</table>
### A Sample of Services Covered by Your Plan:

<table>
<thead>
<tr>
<th>Service</th>
<th>In-network</th>
<th>Out-of-network</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cleaning (prophylaxis)</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Frequency:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Once Every 6 Months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Fluoride Treatments</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Limits:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under Age 14</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Oral Exams</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sealants (per tooth)</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>X-rays</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Basic Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Anesthesia</strong></td>
<td>80%</td>
<td>50%</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Fillings</strong></td>
<td>80%</td>
<td>50%</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Perio Surgery</strong></td>
<td>80%</td>
<td>50%</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Periodontal Maintenance</strong></td>
<td>80%</td>
<td>50%</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Frequency:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Once Every 6 Months (Enhanced)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Repair &amp; Maintenance of Crowns, Bridges &amp; Dentures</strong></td>
<td>80%</td>
<td>50%</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Root Canal</strong></td>
<td>80%</td>
<td>50%</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Scaling &amp; Root Planing (per quadrant)</strong></td>
<td>80%</td>
<td>50%</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Simple Extractions</strong></td>
<td>80%</td>
<td>50%</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Surgical Extractions</strong></td>
<td>80%</td>
<td>50%</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Major Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Bridges and Dentures</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inlays, Onlays, Veneers</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Single Crowns</strong></td>
<td>50%</td>
<td>25%</td>
<td>50%</td>
<td>25%</td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Orthodontia</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Orthodontia</strong></td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Limits:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child(ren)</td>
<td></td>
<td></td>
<td>Child(ren)</td>
<td></td>
</tr>
</tbody>
</table>

This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. **For PPO and or Indemnity members, Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filing material. When Orthodontia coverage is for ”Child(ren)” only, the orthodontic appliance must be placed prior to the age limit set by your plan; If full-time status is required by your plan in order to remain insured after a certain age; then orthodontic maintenance may continue as long as full-time student status is maintained. If Orthodontia coverage is for ”Adults and Child(ren)” this limitation does not apply. The total number of cleanings and periodontal maintenance procedures are combined in a 12 month period. *General Anesthesia – restrictions apply. ‡For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings.

### Manage Your Benefits:

Go to [www.GuardianAnytime.com](http://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.

### Find A Dentist:

Visit [www.GuardianAnytime.com](http://www.GuardianAnytime.com) Click on “Find A Provider”; You will need to know your plan and dental network, which can be found on the first page of your dental benefit summary.

### 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: 00507288

Please call the Guardian Helpline if you need to use your benefits within 30 days of plan effective date.
**EXCLUSIONS AND LIMITATIONS**

- **Important Information about Guardian’s DentalGuard Indemnity and DentalGuard Preferred PPO plans**: This policy provides dental insurance only. Coverage is limited to those 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-DG2000 et al.

- **PPO and Indemnity Special Limitation**: 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
Save Your Unused Claims Dollars For When You Need Them Most

Guardian will roll over a portion of your unused annual maximum into your personal Maximum Rollover Account (MRA). If you reach your Plan Annual Maximum in future years, you can use money from your MRA. To qualify for an MRA, you must have a paid claim (not just a visit) and must not have exceeded the paid claims threshold during the benefit year. Your MRA may not exceed the MRA limit. You can view your annual MRA statement detailing your account and those of your dependents on www.GuardianAnytime.com.

Please note that actual maximum limitations and thresholds vary by plan. Your plan may vary from the one used below as an example to illustrate how the Maximum Rollover functions.

<table>
<thead>
<tr>
<th>Plan Annual Maximum*</th>
<th>Threshold</th>
<th>Maximum Rollover Amount</th>
<th>In-Network Only Rollover Amount</th>
<th>Maximum Rollover Account Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1000</td>
<td>$500</td>
<td>$250</td>
<td>$350</td>
<td>$1000</td>
</tr>
</tbody>
</table>

Maximum claims reimbursement: Claims amount that determines rollover eligibility

Annual Rollover Amount: Additional dollars added to Plan Annual Maximum for future years

In-Network Only Rollover Amount: Additional dollars added to Plan Annual Maximum for future years if only in-network providers were used during the benefit year

Plan Annual Maximum plus Maximum Rollover cannot exceed $2,000 in total

* If a plan has a different annual maximum for PPO benefits vs. non-PPO benefits, ($1500 PPO/$1000 non-PPO for example) the non-PPO maximum determines the Maximum Rollover plan.

Here's how the benefits work:

YEAR ONE: Jane starts with a $1,000 Plan Annual Maximum. She submits $150 in dental claims. Since she did not reach the $500 Threshold, she receives a $250 rollover that will be applied to Year Two.

YEAR TWO: Jane now has an increased Plan Annual Maximum of $1,250. This year, she submits $50 in claims and receives an additional $250 rollover added to her Plan Annual Maximum.

YEAR THREE: Jane now has an increased Plan Annual Maximum of $1,500. This year, she submits $1,200 in claims. All claims are paid due to the amount accumulated in her Maximum Rollover Account.

YEAR FOUR: Jane’s Plan Annual Maximum is $1,300 ($1,000 Plan Annual Maximum + $300 remaining in her Maximum Rollover Account).

For Overview of your Dental Benefits, please see About Your Benefit Section of this Enrollment Booklet.

NOTES:
You and your insured dependents maintain separate MRAs based on your own claim activity. Each MRA may not exceed the MRA limit.

Cases on either a calendar year or policy year accumulation basis qualify for the Maximum Rollover feature. For calendar year cases with an effective date in October, November or December, the Maximum Rollover feature starts as of the first full benefit year. For example, if a plan starts in November of 2013, the claim activity in 2014 will be used and applied to MRAs for use in 2015.

Under either benefit year set up (calendar year or policy year), Maximum Rollover for new entrants joining with 3 months or less remaining in the benefit year, will not begin until the start of the next full benefit year. Maximum Rollover is deferred for members who have coverage of Major services deferred. For these members, Maximum Rollover starts when coverage of Major services starts, or the start of the next benefit year if 3 months or less remain until the next benefit year. (Actual eligibility timeframe may vary. See your Plan Details for the most accurate information.)

Guardian's Dental Insurance is underwritten and issued by The Guardian Life Insurance Company of America or its subsidiaries, New York, NY. Products are not available in all states. Policy limitations and exclusions apply.

Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage.

Policy Form #GP-1-DG2000, et al.
DentalGuard True Group
The Fine Print

This document is a summary of your dental plan. * A complete list of covered services, limitations and exclusions is in your plan document and certificate booklet. The plan pays for covered charges to prevent, diagnose or treat dental disease, defect or injury. Payment is subject to all provisions of the group plan. Insured employees and their qualified insured dependents are covered persons.

Covered Charges: Covered charges are reasonable and customary charges for the dental services named in the List of Covered Dental Services. To be covered, a service must be (a) necessary; (b) appropriate for a given condition; and (c) on the list of covered services. By reasonable, we mean the charge is the dentist's usual charge for the service furnished. By customary, we mean the charge made for the given dental condition isn't more than the usual charge made by most other dentists.

When certain comprehensive dental procedures are performed, other less extensive procedures may be performed prior to, at the same time or at a later date. For benefit purposes under this policy, these less extensive procedures are considered to be part of the more comprehensive procedure.

We only pay for covered charges incurred by a covered person while he or she is insured. A covered charge for a crown, bridge or cast restoration is incurred on the date the tooth is first prepared. A covered charge for any other appliance or dental prosthesis is incurred on the date the first master impression is made. A covered charge for root canal treatment is incurred on the date the pulp chamber is opened. All other covered charges are incurred on the date the services are furnished, and if a service is started while insured, it must be completed within 3 days to be considered for coverage.

Alternate Treatment: If more than one type of service can be used to treat a dental condition, we have the right to base benefits on the least expensive service which is within the range of professionally accepted standards of dental practice as determined by us.

Benefits From Other Plans: If a covered person receives benefits from another plan other than one sponsored by his employer or Medicare, we will coordinate our payments with the benefits from that plan. We do this so the covered person won't receive benefits which exceed the charges incurred. Benefits from other plans cannot be used to meet this plan's deductible.

Deductible: Benefits are paid for covered charges following the payment of a personal cash deductible, which is shown in the Schedule of Benefits.

Family Deductible Limit: If three family members pay the cash deductible in a benefit year, the deductible for all other insured family members will be waived for the rest of that year.

*Please note that due to state mandates, a plan may be slightly different than described in this document.

Payment Rate: After the deductible is satisfied, the plan pays covered charges for preventive, basic, and major services. All benefits are subject to the payment rates and maximum amount payable in any benefit year as shown in the Schedule of Benefits.

Pre-Treatment Review: For all courses of treatment expected to exceed $300 we ask the dentist to submit a report to Guardian describing the proposed treatment and itemizing expected charges.

Proof of Claim: In order to accurately pay for and determine covered charges, it is required that information acceptable to Guardian be provided. This information may, at Guardian's discretion, consist of radiographs, study models, periodontal charting, narratives or other diagnostic materials which document proof of claim and support the necessity of the proposed treatment. If this necessary information is not provided, no benefit or minimum benefits may be allowable.

Late Entries: Except for covered charges due solely to an accident suffered while insured, we don't pay benefits for any charges incurred by a late entrant in the first: (1) 6 months he or she is insured for basic services; (2) 12 months he or she is insured for major services; and (3) if included in the plan, 24 months he or she is insured for orthodontic services. A late entrant is any person who: (1) becomes insured more than 31 days after he is first eligible; or (2) becomes insured again after his coverage lapsed because required payments were not made.

Missing Teeth: A covered person may have one or more congenitally missing teeth or have had one or more teeth lost or extracted before he or she became insured by this plan. We don't pay for a dental prosthesis which replaces such teeth unless the dental prosthesis also replaces one or more eligible natural teeth lost or extracted after the covered person became insured by this plan.

Replacement of Prior Plan: This plan may be replacing the prior plan your employer had with another insurer. If: (1) the covered person was insured by the prior plan; and (2) the covered person was insured by this plan from the start, subject to all other provisions of this plan, the following provisions apply:

- Teeth Extracted While Insured: With the Prior Plan, the replacement of a lost or missing tooth after the date of the prior plan will not be covered.
- Deductible Credit and Benefit Year Maximum Credit - in the first benefit year of this plan, we reduce this plan's deductible by the amount of covered charges applied against the prior plan's deductible and in the first benefit year of this plan, we reduce the maximum benefit payable under this plan by the amount paid under the prior plan. You are required to supply us with proof of the amount of deductible and maximum applied against the prior plan's deductible.

Exclusions: The plan does not pay for:

1. Any restorative, procedure, appliance or dental prosthesis used solely to: (a) alter vertical dimension; (b) restore or maintain occlusion, except to the extent that this plan covers orthodontic treatment; (c) treat a condition caused by attrition or abrasion; or (d) split or stabilize teeth for periodontal reasons.
2. Replacement of a lost, missing or stolen appliance or dental prosthesis or the fabrication of a spare appliance or dental prosthesis.
3. Any service or procedure associated with the placement, repair, maintenance or removal of a dental implant and any incremental charges to other covered services as a result of the presence of a dental implant.
4. Any service furnished solely for cosmetic reasons.
5. Replacing an existing appliance or dental prosthesis with a like appliance or dental prosthesis or any appliance or dental prosthesis unless (a) it is at least 10 years old and can't be made usable; or (b) it is damaged while in the covered person's mouth in an injury suffered while insured, and can't be made serviceable.
6. The replacement of extracted or missing third molars/wisdom teeth.
7. Treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth.
8. Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
9. Any procedure, appliance, dental prosthesis, modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ).
10. Treatment needed due to: (a) an on-the-job or job-related injury; or (b) a condition for which benefits are payable by Worker's Compensation or similar laws.
11. Treatment for which no charge is made. This usually means treatment furnished by: (a) the covered person's employer, labor union or similar group, in its dental or medical department or clinic; (b) a facility owned or run by any governmental body; and (c) any public program, except Medicaid, paid for or sponsored by any governmental body.
12. Evaluations and consultations for non-covered services; detailed and extensive oral evaluations.
13. Orthodontic treatment, unless the benefit provision provides specific benefits or orthodontic treatment.
14. Any procedure performed in conjunction with, as part of or related to a non-covered procedure.
15. Any procedure not specifically listed as a covered benefit

Preventive Services

Oral Exams, Evaluations and Office Visits:
- Office visits, evaluations, examinations, re-evaluations - a total of one in any six-month period.
- Emergency oral evaluations - a total of one in any six-month period. Covered if no other treatment, other than radiographs, is performed in the same visit.
- After hours office visit or emergency palliative treatment and other non-routine, unscheduled visit a total of one in a six-month period.
Covered only when no other treatment, other than radiographs, is performed in the same visit.

**Prophylaxis:** A total of one prophylaxis or periodontal maintenance procedure (considered under Periodontal Services) in any six-month period.

**Fluoride Treatment (Topical Application):** Covered persons under age 14, one treatment in any six-month period.

**Space Maintainers:** Under age 16, initial appliance only.

**Fixed and Removable Appliances to Inhibit Thumbucking:** Covered persons under age 14, initial appliance only.

**Radiographs:**
- Full mouth, complete series or panoramic radiograph - Either, but not both, once in any 60-month period.
- Bitewing films - Either a maximum of four bite-wing films or a set (seven to eight films) of vertical bitewings, in one visit, once in any 12-month period.
- Intraoral periapical or occlusal films, single films

**Topical Sealants:** One treatment on unrestored permanent molar teeth in any 36-month period and restricted to covered persons under age 16.

**Basic Services**

Diagnostic consultation for covered services with a dentist other than the one providing treatment. Once in 12-months for each dental specialty. We pay only if no other treatment, other than radiographs, is rendered during the visit.

**Diagnostic Casts:** When needed to prepare a treatment plan for complex treatment.

**Histopathologic Examinations:** When performed in conjunction with a tooth-related biopsy.

**Basic Restorative Services:** Multiple restorations on one surface are considered one restoration. Replacement of existing amalgam and resin restorations will only be considered for payment if at least 12-months have passed since the previous restoration was placed if the covered person is under age 19, and 36-months if the covered person is age 19 and older. Also see the ‘Major Restorative Services’ section of this insert.

- Amalgam restorations
- Resin restorations (anterior teeth only). Coverage for restorations on posterior teeth is limited to the corresponding amalgam benefit. Restorations that do not involve the incisal edge are considered a single surface filling.
- Stainless steel crown, prefabricated resin crown, and resin-based composite crown, once per tooth in any 24-month period. Temporary and provisional crowns are considered to be part of the permanent restoration.

**Crown and Prosthetic Restorative Services:** Also see the ‘Major Restorative Services’ section of this insert.

- Crown, bridge and denture repairs
- Recementation of inlay or onlay, crown and bridge, recementations performed more than 12-months after the initial insertion
- Adding teeth to partial dentures to replace extracted natural teeth
- Denture base, once per denture in any 24-month period
- Denture reline, full or partial denture - once per denture in any 24-month period
- Denture adjustments
- Tissue conditioning - a maximum of one treatment, per arch, in any 12-month period

**Endodontic Services:** Allowance includes diagnostic, treatment and final radiographs, and cultures and tests, local anesthetic and routine follow-up care, but excludes final restoration.

- Pulp capping, permanent teeth
- Vital pulpotomy
- Root canal treatment
- Apexification, a maximum of three visits
- Apicoectomy, once per root, per lifetime
- Root amputation, once per root, per lifetime
- Retrograde filling, once per root, per lifetime
- Hemisection, including any root removal, once per tooth

**Periodontal Services:** Allowance includes the treatment plan, local anesthetic and post-treatment care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probing of each tooth involved.

- Periodontal maintenance procedure - a total of one prophylaxis (covered under Preventive) or periodontal maintenance procedure in any six-month period. Coverage for periodontal maintenance is considered upon evidence of completed active periodontal therapy (periodontal scaling and root planing or periodontal surgery).
- Scaling and root planing, once per quadrant in any 24-month period.
- Full mouth debridement, once in any 36-month period. Considered only when no diagnostic, preventive, periodontal service or periodontal surgery procedure has been performed in the previous 36-month period.

**Surgical Services:** Allowance includes the treatment plan, local anesthetic and post-surgical care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probing of each tooth involved.

- Either Gingivectomy or Crown lengthening, once per tooth in any 12-month period.
- One of the following once per quadrant, in any 36-month period: (a) Gingivectomy or gingivoplasty, per quadrant; (b) Osseous surgery, including scaling and root planing, flap entry and closure, per quadrant; (c) Gingival flap procedure, including scaling and root planing, per quadrant; (d) Distal or proximal wedge, not in conjunction with osseous surgery; (e) Surgical revision procedure, per tooth.
- One of the following, once per quadrant in any 36-month period: Pedicle or free soft tissue grafts, including donor site, or subepithelial connective tissue graft procedure, when the tooth is present.

- Either guided tissue regeneration or bone replacement grafts, once per area or tooth, per lifetime.
  (a) Limited occlusal adjustment - a total of two visits, covered only when done within a six-month period after covered scaling and root planing or osseous surgery; (b) Occlusal guards, covered only when done within a six-month period after osseous surgery, once per lifetime.

**Oral Surgery:** Allowance includes diagnostic and treatment radiographs, the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by your medical plan.

- Uncomplicated extraction, one or more teeth
- Root removal - non-surgical extraction of exposed roots
- Surgical removal of erupted teeth, residual tooth roots and impacted teeth
- Alveolectomy
- Removal of exostosis, maxilla or mandible
- Incision and drainage of abscess
- Frenectomy, Frenectomy, Frenotomy
- Biopsy and examination of tooth related oral tissue
- Surgical exposure of impacted or unerupted tooth to aid eruption
- Excision of tooth related tumors, cysts and neoplasms, hyperplastic tissue, periconal gingiva
- Excision or destruction of tooth related lesion(s)
- Vestibuloplasty

**Other Services:** General anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, including nitrous oxide, when administered in connection with covered surgical procedures.

**Major Services**

**Major Restorative Services:** Full and 3/4 cast metal and porcelain crowns, inlays, onlays, labial veneers, and crown buildups are covered only when needed because of decay or injury, and only the tooth cannot be restored with amalgam or composite filling material. Post and cores are covered only when needed due to decay or injury. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Limited to permanent teeth only. Also see the ‘Basic Restorative Services’ section of this insert.

**Prosthodontic Services:** Specialized techniques and characterization are not covered. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement.

- Bridge abutments and Bridge pontics
- Complete or Immediate dentures, upper or lower
- Upper and lower partial dentures - allowance includes base, clasps, rests and teeth
- Interim partial denture (staple), covered on anterior teeth only
- Removable unilateral partial, one piece cast metal, including clasps and teeth

Php 3533 (7/01)  
(DGCC) 2001-2229

The Guardian Life Insurance Company of America
New York, NY 10004 www.gl.com
Employee Benefits Hotline (EBH)

Benefit specialists are available to answer questions as you sign up for your Guardian benefits

<table>
<thead>
<tr>
<th>Toll-free Phone</th>
<th>Monday-Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-888-600-1600</td>
<td>6:00 a.m. – 7:30 p.m. CST</td>
</tr>
<tr>
<td></td>
<td>5:00 a.m. – 6:30 p.m. MST</td>
</tr>
<tr>
<td></td>
<td>4:00 a.m. – 5:30 p.m. PST</td>
</tr>
</tbody>
</table>

STEP 1:  Ask yourself these questions to determine if you should call the Employee Benefits Hotline.
If you answer “yes” to any of these questions, prepare to contact the Hotline (go to STEP 2):

- Do I need help completing my enrollment forms?
- Do I have questions about the benefits covered under the plans my employer is offering?
- Do I need to make my first dental appointment immediately following my enrollment?
  (If so, it’s suggested you contact the Hotline at least 72 hours prior to your visit so you can ensure your provider has your coverage information. Coverage begins on your plan’s effective date.)

STEP 2:  Prepare to contact the Hotline

- Name of the company you work for
- Your company’s group number
  (Both can be found on the front of the enrollment materials)

STEP 3:  Call 888-600-1600 to get answers!

- Press #1 to identify yourself as an employee.
- At the next prompt:
  - Press #1 if your questions relate to Dental Benefits
  - Press #0 for all other questions
- Enter your company’s group number

IMPORTANT NOTE: The Employee Benefits Hotline provides pre-enrollment support in over 50 languages! Once you are enrolled in a plan, you will receive additional information and new toll-free phone numbers. If you are looking for a dentist or vision provider who participates in your plan, go to www.Guardian Anytime.com.
It’s easy to use your dental benefits. You don’t even need an ID card!

Your Guardian dental benefits are designed to save you money on important treatments to keep you healthy, by making it easy for you to find a network dentist in your area. The best way to save money is to see a dentist in your network.

It’s easy to find a Guardian network dentist:

- Under Dental Plan, choose PPO. Your PPO type is DentalGuard Preferred.
- Follow the easy steps to search.
- You can also find a dentist on the go from your smart phone – simply download our app at www.GuardianAnytime.com/mobile.

You’ll need your Group ID number for your first visit with the dentist. The Group ID number is included in your enrollment material and available from your employer.*

Once your plan is activated, you can also view and print an image of your ID card from www.GuardianAnytime.com or through our smart phone app. Use your Group ID number to register.

*Your Group ID Number is located on the front of your enrollment materials and on the top right corner of the enrollment form.

2012-8231
Guardian’s network in the palm of your hand.

The best way to save money through your dental and vision benefits is to see a provider in your network. Guardian makes it easy to find a dentist or vision provider near you, online or on the go! Plus, you can access your member ID card to present at your visit.

Search on the go!

It’s fast and easy to find a provider from your smart phone through our Guardian Anytime mobile app. It’s easy to download and use! Simply search by location or name.

View/Print your Member ID Card

You no longer need to show your dental or vision provider a paper ID card. Simply access an image of your card through Guardian Anytime Mobile and show them at your visit!

You can also Find a Provider at our website www.GuardianAnytime.com. Customize your search, get side-by-side comparisons, or create a quick list of “favorite” providers and more!
DentalGuard Preferred Dentist Nomination Form

I would like to nominate my dentist for inclusion in the DentalGuard Preferred Provider Network. I understand that my name may be used when contacting my dentist to inform him/her of my desire for them to join the network. For more information, visit us online at www.GuardianLife.com.

DATE: ______________________

Employer: ______________________________________________________

Patient: _______________________________________________________

Address: ______________________________________________________

City/State/Zip: __________________________________________________

Phone: _______________________________________________________

Fax: _______________________________________________________

E-mail: _______________________________________________________

DENTIST INFO

Name: _______________________________________________________

Address: ______________________________________________________

City/State/Zip: __________________________________________________

Phone: _______________________________________________________

Specialty: ______________________________________________________

Please submit completed form to: Guardian
DentalGuard Preferred
P.O. Box 2465
Spokane, WA 99210-9817
or FAX to: 509-468-6550
**Employer Name:** Canisius College  
**Group Plan Number:** 00507288  
**Benefits Effective:** __________

**PLEASE CHECK APPROPRIATE BOX**  
- Initial Enrollment  
- Re-Enrollment  
- Add Employee/Dependents  
- Drop/Refuse Coverage  
- Information Change  
- Increase Amount  
- Family Status Change

**Class:** __________  
**Division:** __________  
**Subtotal Code:** __________  
(Please obtain this from your Employer)

**About You:**  
**First, MI, Last Name:** __________

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

**Gender:**  
- M  
- F  
**Date of Birth (mm-dd-yyyy):** __________

<table>
<thead>
<tr>
<th>Email Address:</th>
</tr>
</thead>
</table>
| 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 that you, as a taxpayer, claim; who relies on you for financial support; and for whom you qualify for a dependency tax exception. Dependency 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.

<table>
<thead>
<tr>
<th>Spouse (First, MI, Last Name)</th>
<th>Gender</th>
<th>Date of Birth (mm-dd-yyyy)</th>
<th>Status (check all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M F</td>
<td>___ - ___ - ___</td>
<td>Student (post high school)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Non standard dependent</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>State of Residence:</td>
</tr>
</tbody>
</table>

| Child/Dependent 1:  
- Add  
- Drop  
**Gender:**  
- M  
- F  
**Date of Birth (mm-dd-yyyy):** __________  
**Status (check all that apply):**  
- Student (post high school)  
- Non standard dependent  
- State of Residence: __________

| Child/Dependent 2:  
- Add  
- Drop  
**Gender:**  
- M  
- F  
**Date of Birth (mm-dd-yyyy):** __________  
**Status (check all that apply):**  
- Student (post high school)  
- Non standard dependent  
- State of Residence: __________

| Child/Dependent 3:  
- Add  
- Drop  
**Gender:**  
- M  
- F  
**Date of Birth (mm-dd-yyyy):** __________  
**Status (check all that apply):**  
- Student (post high school)  
- Non standard dependent  
- State of Residence: __________

| Child/Dependent 4:  
- Add  
- Drop  
**Gender:**  
- M  
- F  
**Date of Birth (mm-dd-yyyy):** __________  
**Status (check all that apply):**  
- Student (post high school)  
- Non standard dependent  
- State of Residence: __________
**Dental Coverage:** You must be enrolled to cover your dependents. Check only one box.

<table>
<thead>
<tr>
<th>Option 1: Plan A - Base</th>
<th>Option 2: Plan B - Dr not Par</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only EE, Spouse &amp; Dependent/Child(ren)</td>
<td>I do not want this coverage. If you do not want this Dental Coverage, please mark all that apply:</td>
</tr>
<tr>
<td>☐</td>
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</tr>
</tbody>
</table>

I understand that my dependent(s) cannot be enrolled for coverage if I am not enrolled for that coverage.

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.

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.

Plan design limitations and exclusions may apply. For complete details of coverage, please refer to your benefit booklet. State limitations may apply.

Your coverage will not be effective until approved by a Guardian or its designated underwriter.

I hereby apply for the group benefit(s) that I have chosen above.

I understand that I must meet eligibility requirements for all coverages that I have chosen above.

I agree that my employer may deduct premiums from my pay if they are required for the coverage I have chosen above.

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 state that the information provided above is true and correct to the best of my knowledge.

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 the purpose of misleading, information concerning any fact material thereto, 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).

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.)

**Signature**

- I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.
- 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.
- 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.
- Plan design limitations and exclusions may apply. For complete details of coverage, please refer to your benefit booklet. State limitations may apply.
- Your coverage will not be effective until approved by a Guardian or its designated underwriter.
- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- I agree that my employer may deduct premiums from my pay if they are required for the coverage I have chosen above.
- 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 state that the information provided above is true and correct to the best of my knowledge.

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**SIGNATURE OF EMPLOYEE X**

DATE

---

**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.
<table>
<thead>
<tr>
<th>State</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecticut, Iowa, Kansas, Nebraska, Oregon, and Vermont:</td>
<td>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.</td>
</tr>
<tr>
<td>Delaware, Indiana and Oklahoma:</td>
<td>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.</td>
</tr>
<tr>
<td>District of Columbia:</td>
<td>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.</td>
</tr>
<tr>
<td>Florida:</td>
<td>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.</td>
</tr>
<tr>
<td>Kentucky:</td>
<td>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.</td>
</tr>
<tr>
<td>Louisiana and Texas:</td>
<td>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.</td>
</tr>
<tr>
<td>Maine, Tennessee, Virginia and Washington:</td>
<td>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.</td>
</tr>
<tr>
<td>Maryland:</td>
<td>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.</td>
</tr>
<tr>
<td>Rhode Island:</td>
<td>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.</td>
</tr>
<tr>
<td>Minnesota:</td>
<td>A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.</td>
</tr>
<tr>
<td>New Hampshire:</td>
<td>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 subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. § 638:20.</td>
</tr>
<tr>
<td>New Jersey:</td>
<td>Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.</td>
</tr>
<tr>
<td>New Mexico:</td>
<td>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 fines and criminal penalties or denial of insurance benefits.</td>
</tr>
<tr>
<td>Ohio:</td>
<td>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.</td>
</tr>
<tr>
<td>Pennsylvania:</td>
<td>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.</td>
</tr>
</tbody>
</table>