

2012 Dental Plans (rates are monthly)

MONTHLY RATES	Guardian Dental Guard Preferred PLAN 1	Guardian Dental Guard Preferred PLAN 2	Guardian VSP VISION
Employee Only	Contact Simple HR Benefits Department for Rates		
Employee and Spouse			
Employee and Child			
Employee and Family			

GUARDIAN DENTALGUARD PREFERRED PLAN 1 BENEFIT SUMMARY

Benefit Structure	IN NETWORK	OUT OF NETWORK
Type I - Preventive/Diagnostic Fluoride Treatments (under age 19), X-Rays, Cleanings, Periodic Exams Benefit Year Deductible Company Pays	-0- 100%	-0- 100%
Type II - Restorative Simple Extractions, Fillings, Stainless Steel Crown Benefit Year Deductible Company Pays	\$50 80%	\$100 80%
Type III - Major Restorative Removal of Impacted Teeth, Oral Surgery, Root Canals, Bridges, Crowns, Dentures, Partials Benefit Year Deductible Company Pays	\$50 50%	\$100 50%
Maximum Benefit Year Type I, II, and III	\$2,000 per person	\$1,000 per person
Claim Payment Basis	Negotiated Fee Schedule	90 th Percentile of UCR
Type IV – Orthodontia (ages 6-18) Lifetime Deductible Company Pays Lifetime Benefit	-0- 50% \$1,500	-0- 50% \$1,500

GUARDIAN DENTALGUARD PREFERRED PLAN 2 BENEFIT SUMMARY

Benefit Structure	IN NETWORK	OUT OF NETWORK
Type I - Preventive/Diagnostic Benefit Year Deductible Company Pays	\$50 80%	\$100 80%
Type II - Restorative Benefit Year Deductible Company Pays	\$50 70%	\$100 70%
Claim Payment Basis	Negotiated Fee Schedule	90 th Percentile of UCR
Maximum Benefit Year Type I and II	\$1,000	\$1,000

Plan Benefit Summaries are available upon request



The Guardian Life Insurance Company of America
 The Guardian Insurance & Annuity Company, Inc.

Northeast Regional Office
 PO Box 26040
 Lehigh Valley PA 18002-6040

Bridgewater Office
 PO Box 425
 E. Bridgewater MA 02333-0425

Western Regional Office
 PO Box 2454
 Spokane WA 99210-2454

**Enrollment Form
 For Non-Medical Coverages**

Planholder Name (Company Name) Simple HR				Group Plan No.		Division		Class		
Planholder Street Address					City			State	Zip	
PLEASE CHECK REASON FOR COMPLETING: <input type="checkbox"/> INITIAL APPLICATION CHANGE: <input type="checkbox"/> INCREASE <input type="checkbox"/> ADD DEPENDENT(S)/RIDER(S) <input type="checkbox"/> PREMIUM CLASS										
GIVE THE FOLLOWING INFORMATION FOR EACH PERSON TO BE INSURED										
Name (Last, First, Middle Initial)					Sex	Birthdate		Employee Social Security #		
Employee:					<input type="checkbox"/> M <input type="checkbox"/> F					
Are you <input type="checkbox"/> Actively at work <input type="checkbox"/> Retired										
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed					Dependent Children: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Date of Marriage:										
Date of Full Time Employment		Hrs. Worked / Week	Annual Salary \$	Occupation / Job Title			Beneficiary(s)			
							Name (Last, First, Middle)	Relationship	%	
Employee's Street Address			City		State	Zip	Name (Last, First, Middle)	Relationship	%	
Business Phone #		Home Phone #		Email Address						
Name (Last, First, Middle Initial)					Sex	Birthdate		Dependent Social Security #		
Spouse:					<input type="checkbox"/> M <input type="checkbox"/> F					
Child: F/T Student? <input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> M <input type="checkbox"/> F					
Child: F/T Student? <input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> M <input type="checkbox"/> F					
Child: F/T Student? <input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> M <input type="checkbox"/> F					
Child: F/T Student? <input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> M <input type="checkbox"/> F					
(1) Are any dependent children adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" indicate name and date of placement:										
(2) Have you included stepchildren? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" indicate name(s): Are they dependent on you for support and maintenance? <input type="checkbox"/> Yes <input type="checkbox"/> No										
(3) Do any dependents reside at a different address than indicated above? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" indicate name and address:										
(4) Do any dependent children have a mental or physical handicap or developmental disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" indicate name(s):										

Please remember:

- The standard waiting time for these benefits is 90-days to first day of the following month.
- Please complete this application and forward to Simple HR (Fax: 850-650-9934).
- You must elect or decline participation in the benefits offered on the reverse side of this form.
- Your deductions will always begin 30-days prior to your effective date of coverage.
- Please sign and date your application.

VISION COVERAGE ELECTION: Issued by: The Guardian Life Insurance Company of America

- Employee
- Employee + ONE Dependent (One Child or Spouse)
- Employee + TWO OR MORE Dependents (Family or Children)
- I decline coverage for Employee Spouse Child(ren). I understand if I elect coverage at a later date, late entrant penalties will apply. If declining coverage, are you covered under another vision plan? Yes No
- If declining dependent coverage, are your dependents covered under another vision plan? Yes No

DENTAL COVERAGE ELECTION: Issued by: The Guardian Life Insurance Company of America

- Employee High Option
- Spouse Low Option
- Child(ren)
- I decline coverage for Employee Spouse Child(ren). I understand if I elect coverage at a later date, late entrant penalties will apply. If declining coverage, are you covered under another dental plan? Yes No
- If declining dependent coverage, are your dependents covered under another dental plan? Yes No

- I hereby apply for the group benefit(s) indicated above.
- I understand I must be actively at work or my life coverage will not take effect until I have completed a waiting period (as defined in the Group Plan) of full time service. This requirement does not apply to eligible retirees.
- I understand that life insurance coverage for my dependents will not take effect if a dependent, other than a newborn is confined to a hospital or other health care facility, or is unable to perform the normal activities of someone of like age and sex.
- I authorize my employer to take deductions from my pay or agree that the contributions be added to my dues; if they are required for the insurance.
- The information provided above is true and correct to the best of my knowledge.
- 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.

X SIGNATURE OF EMPLOYEE	DATE
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PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS AND SUBMIT THIS FORM TO GUARDIAN

CEF-FL-1999-esu



Benefit Summary

for Dental Maximum Rollover Plan has been prepared for the employees of:

Simple HR – High Option

In-Network Deductible- \$50 (*Waived for Preventive Services)
Out-of-Network Deductible- \$100 (*Waived for Preventive Services)

Services	Percentage Paid	
	In-Network	Out-of-Network
Preventive Services*	100%	100%
Emergency Palliative Treatment		
Oral Examination - every six months		
X-Rays - four bitewings every twelve months full mouth series every five years		
Teeth Cleaning - every six months		
Fluoride Treatments for Children - every six months under age 14		
Space Maintainers for Children - under age 16		
Topical Sealants for unrestored molar teeth		
-one treatment for child(ren) under 16 in a three (3) year period		
Basic Services	80%	80%
Laboratory Test		
Diagnostic Consultation- one per year		
Fillings: Amalgam, Acrylic, & Posterior Composite		
Crowns: Stainless Steel		
Repairs of dentures, bridgework, crowns, etc.		
Injectable Antibiotics- for treatment of a dental condition only		
Major Services	50%	50%
Bridges Installation-fixed and removable		
Oral Surgery- Uncomplicated extractions		
Dentures- Full and Partial		
Crowns: Acrylic Metal, Porcelain		
Endodontic Services/Root Canal Therapy		
Periodontal Services		
General Anesthesia- surgical procedures only		
Inlays		
Onlays		
Posts		
Implants		
Orthodontic Services	50%	50%
\$1,500 Lifetime Maximum for child(ren) under age 19		
The deductible does not apply to Orthodontic services.		



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The Guardian Life Insurance Company of America, New York, NY

2004-7883

- There is a **\$2,000** in-network and **\$1,000** out of network annual maximum for Preventive, Basic and Major services combined, subject to the maximum rollover.
- **Maximum Rollover:** With Maximum Rollover, we'll roll over a portion of each member's unused annual maximum, called the Maximum Rollover Amount, into his or her Maximum Rollover Account (MRA). The MRA can be used in future years, if a member reaches the plan's Annual Maximum.

Even better, if a member uses the services of Preferred Providers exclusively during the benefit year, we'll increase the amount credited to his or her MRA to the In-network Only Maximum Rollover Amount.

To qualify, a member must submit a claim and not exceed the paid claims Threshold during the benefit year. The employee and each insured dependent maintain separate MRAs based on their own claim activity. Each member's MRA may not exceed the MRA limit.

PLAN ANNUAL MAXIMUM *	THRESHOLD	MAXIMUM ROLLOVER AMOUNT	IN-NETWORK ONLY MAXIMUM ROLLOVER AMOUNT	MAXIMUM ROLLOVER ACCOUNT LIMIT
\$1000	\$500	\$250	\$350	\$1000

* 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.

- *Deductible is waived for Preventive services. 3 individual deductibles per family.
- Eligible dependents include your unmarried children up to age 20 or 26, if the child is dependent upon the employee for support and is: (i) living in the employee's household; or (ii) a full-time or part-time student.
- Employee/Dependents enrolling outside of the plan eligibility period may be subject to Late Entrant¹ penalties.
- All out of network services are based on usual, reasonable, and customary rates for given area.
- Dental Claims - P. O. Box 2459, Spokane, WA 99210-2459, ph: 1-800-541-7846, fax: 509-468-4590.
- Guardian has contracted with dental providers to provide discounts off services and procedures to Guardian dental plan members. To locate a provider, please reference our On-Line Provider Directory at www.GuardianLife.com.
- Pre-determination Review - Guardian will gladly assist you and your dentist by determining what benefits could be payable for services and procedures over \$300. Have your dentist fax your treatment plan to Guardian, note that it is a pre-determination review and we will let your dentist know what benefits would be payable. (This includes orthodontic treatment if your plan includes it)
- **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

¹ A late entrant is a person who becomes insured more than 31 days after he is eligible; or becomes insured again, after his coverage lapsed because he did not make required payments. We won't cover charges incurred by a late entrant for (1) Group II (basic) services until 6 months from the date he is insured by this plan; and (2) Group III (major) services until 12 months from the date he is insured by this plan and Group IV (orthodontics) services until 24 months from the date he is insured by this plan.

DentalGuard General Limitations and Exclusions: 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, 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.

This handout is for illustrative purposes. You will receive benefit booklets. If there is a discrepancy between this handout and your benefit booklet, the benefit booklet prevails.



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The Guardian Life Insurance Company of America, New York, NY

2004-7883

Benefit Summary

for Dental has been prepared for the employees of:

Simple HR – Low Option

In-Network Deductible- \$50
Out-of-Network Deductible- \$100

	In- or Out-of-Network Percentage Paid
Services	
Preventive Services	80%
Emergency Palliative Treatment	
Oral Examination - every six months	
X-Rays - four bitewings every twelve months full mouth series every five years	
Teeth Cleaning - every six months	
Fluoride Treatments for Children - every six months under age 14	
Space Maintainers for Children - under age 16	
Topical Sealants for unrestored molar teeth	
-one treatment for child(ren) under 16 in a three (3) year period	
Basic Services	70%
Laboratory Test	
Diagnostic Consultation- one per year	
Fillings: Amalgam & Acrylic	
Crowns: Stainless Steel	
Repairs of dentures, bridgework, crowns, etc.	
Endodontic Services/Root Canal Therapy	
Periodontal Services	
Injectable Antibiotics- for treatment of a dental condition only	



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Benefit Summary

- There is a \$1,000 annual maximum for Preventive and Basic services combined.
- 3 individual deductibles per family.
- Eligible dependents include your unmarried children up to age 20 or 26, if the child is dependent upon the employee for support and is: (i) living in the employee's household; or (ii) a full-time or part-time student.
- Employee/Dependents enrolling outside of the plan eligibility period may be subject to Late Entrant¹ penalties.
- All out of network services are based on usual, reasonable, and customary rates for given area.
- Guardian has contracted with dental providers to provide discounts off services and procedures to Guardian dental plan members. To locate a provider, please reference our On-Line Provider Directory at www.GuardianLife.com.
- Dental Claims - P. O. Box 2459, Spokane, WA 99210-2459, ph: 1-800-541-7846, fax: 509-468-4590.
- Pre-determination Review - Guardian will gladly assist you and your dentist by determining what benefits could be payable for services and procedures over \$300. Have your dentist fax your treatment plan to Guardian, note that it is a pre-determination review and we will let your dentist know what benefits would be payable.

¹ A late entrant is a person who becomes insured more than 31 days after he is eligible; or becomes insured again, after his coverage lapsed because he did not make required payments. We won't cover charges incurred by a late entrant for Group II (basic) services until 6 months from the date he is insured by this plan.

DentalGuard General Limitations and Exclusions: 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, 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.
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**Simple HR
Vision Service Plan (VSP) Full Feature Program
Benefit Illustration**

Plan Features:

	Benefit Details	
	In-network	Out-of-network
Eye Exams		
Frequency: Every 12 Months	\$10.00 Copay	\$ 46.00 Maximum after Copay
Lenses		
Frequency: Every 12 Months		
Single Vision	\$25.00 Copay	\$ 47.00 Maximum after Copay
Bifocal	\$25.00 Copay	\$ 66.00 Maximum after Copay
Trifocal	\$25.00 Copay	\$ 85.00 Maximum after Copay
Lenticular	\$25.00 Copay	\$125.00 Maximum after Copay
Contact Lenses*		
Frequency: Every 12 Months		
Medically Necessary	\$25.00 Copay	\$210.00 Maximum after Copay
Elective	\$120.00 Maximum (Copay Does Not Apply)	
Frames	\$120.00 Retail Allowance** \$ 47.00 Maximum after Copay	
Frequency: Every 24 Months		

*If you choose contact lenses, you will not be eligible to receive lenses for 12 months and a frame for 24 months following the date contacts were obtained.

**Approximately 15,000 frames are covered in full. Frames not fully covered are offered at a discounted cost. If you select a frame that exceeds the retail allowance, the plan will cover 20% of the amount above the allowance. You must pay the rest.

Note: Lens coverage includes polycarbonate lenses for children up to the plan's non-student dependent child age limits 19 (26 full-time student).

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; and 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-VSN-96-VIS et al.

This handout is for illustrative purposes. You will receive benefit booklets when your enrollment application is processed. If there is a discrepancy between this handout and your benefit booklet, the benefit booklet prevails.