

Benefit and Cost Summary

for Dental Incentive Plan has been prepared for the members of:

The Greater Rochester Association of Realtors®

Deductible- \$50 individual (*Waived for Preventive Services)

Service Category	Co-Insurance Level**	
	Plan Year	
Preventive Services*	1	100%
	2	100%
	3 and after	100%
Emergency Palliative Treatment		
Oral Examination - every six months		
X-Rays - 4 bitewings every 12 months, full mouth series every 5 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	1	50%
	2	60%
	3 and after	80%
Laboratory Test		
Diagnostic Consultation- one per year		
Fillings: Amalgam, Silicate & Acrylic		
Oral Surgery- Uncomplicated extractions		
General Anesthesia- surgical procedures only		
Injectable Antibiotics- for treatment of a dental condition only		
Major Services	1	25%
	2	40%
	3 and after	50%
Bridges Installation-fixed and removable		
Dentures- Full and Partial		
Crowns: Acrylic Metal, Porcelain		
Repairs of dentures, bridgework, crowns, etc.		
Endodontic Services/Root Canal Therapy		
Periodontal Services		
Inlays		
Onlays		
Posts		

**Any year an insured does not receive preventive care; the insured's benefit level for the following year will revert to the Year 1 level (or remain the same if it is the first year an insured is covered).



GUARDIAN®

Benefit and Cost Summary

- There is a \$750 annual maximum for Preventive, Basic and Major services combined.
- *Deductible is waived for Preventive services. 3 individual deductibles per family.
- Children are covered up to age 20 or 26 if a full 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.
- **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.

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.

6/27/2007



GUARDIAN®

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

2004-6242



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

GG-013499NY
Enrollment Form
For Non-Medical Coverages

- Midwest Regional Office
P.O. Box 8012
Appleton, WI 54912-8012
 Northeast Regional Office
P.O. Box 26040
Lehigh Valley, PA 18002-6040
 Bridgewater Office
P.O. Box 425
E. Bridgewater, MA
02333-0425
 Western Regional Office
P.O. Box 2454
Spokane, WA 99210-2454

Planholder Name (Company Name)		Group Plan No.	Division	Class
Planholder Street Address		City	State	Zip
MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced				
PLEASE CHECK REASON FOR COMPLETING: <input type="checkbox"/> INITIAL APPLICATION CHANGE: <input type="checkbox"/> ADD DEPENDENT(S) <input type="checkbox"/> TERMINATE A FAMILY MEMBER <input type="checkbox"/> ADDRESS <input type="checkbox"/> NAME <input type="checkbox"/> DELETE COVERAGE DATE OF CHANGE ___/___/___ REASON FOR CHANGE _____				
GIVE THE FOLLOWING INFORMATION FOR EACH PERSON TO BE INSURED				
Name (Last, First, Middle Initial)		Sex	Birthdate	Employee's Social Security #
Employee:		<input type="checkbox"/> M <input type="checkbox"/> F		
Spouse:		<input type="checkbox"/> M <input type="checkbox"/> F		Date of Marriage / /
Child:		<input type="checkbox"/> M <input type="checkbox"/> F		Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No
Child:		<input type="checkbox"/> M <input type="checkbox"/> F		Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No
Child:		<input type="checkbox"/> M <input type="checkbox"/> F		Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No
Child:		<input type="checkbox"/> M <input type="checkbox"/> F		Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No
(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): (3) Are they dependent on you for support and maintenance? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Date of Full Time Employment	Hrs. Worked / Week	Occupation / Job Title		
Employee's Street Address		City		
State	Zip	Business Phone #	Home Phone #	
DENTAL				
Employee:		Spouse:		Child(ren):
<input type="checkbox"/> I elect coverage.		<input type="checkbox"/> Yes <input type="checkbox"/> No***		<input type="checkbox"/> Yes <input type="checkbox"/> No***
<input type="checkbox"/> I decline coverage. 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? <input type="checkbox"/> Yes <input type="checkbox"/> No				
*** If declining dependent coverage, are your dependents covered under another dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No				
DECLINATION OF COVERAGE:				
Proof of insurability does not apply to dental, but I will be considered a late entrant and my dental benefits will be limited for specific periods of time. However, I and/or my dependents will not be subject to late entrant penalties if dental coverage under another plan is being discontinued as a result of termination of another plan's coverage, loss of employment, death of spouse, divorce, or where a court has ordered coverage be provided for an eligible spouse or eligible minor child(ren), and application for this plan and documentation of the loss of other coverage is received within 31 days of the termination of such coverage.				
• I hereby apply for the group benefit(s) indicated above. • I understand I must be actively at work or my coverage will not take effect until I have completed a waiting period (as defined in the Group Plan) of full time service. • 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 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 may be guilty of insurance fraud.				
X SIGNATURE OF EMPLOYEE				DATE

PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS AND SUBMIT THIS FORM TO GUARDIAN