



Group Number: 464193

Metro Corp.

Here you'll find information about your following employee benefit(s). Be sure to review the enclosed - it provides everything you need to sign up for your Guardian benefits.

PLAN HIGHLIGHTS

- Dental

Questions? Concerns?

Helpline (888) 600-1600

Call weekdays, 7:00 AM to 8:30 PM, EST.

And refer to your plan number: 464193

Welcome

Dear Metro Corp. Employee,

We're pleased to tell you that Guardian will be our dental coverage provider this year. This booklet provides a highlight of your plan benefits. Please review this information carefully, complete your enrollment/waiver form, and return it to Human Resources. Thank you.

Metro Corp.

Dental Benefit Summary

Group Number: 464193

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 \$1,400¹? 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 or 2: With your **Base or Buy up** plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist.

Your Dental Plan	Option 1: Base		Option 2: Buy up	
Your Network is	DentalGuard Preferred		DentalGuard Preferred	
Your Semi-monthly premium	\$16.86		\$24.31	
You and spouse	\$33.76		\$48.63	
You and child(ren)	\$41.83		\$54.65	
You, spouse and child(ren)	\$58.70		\$78.96	
Calendar year deductible	<i>In-Network</i>	<i>Out-of-Network</i>	<i>In-Network</i>	<i>Out-of-Network</i>
Individual	\$50	\$50	\$50	\$50
Family limit	3 per family		3 per family	
Waived for	Preventive	Preventive	Preventive	Preventive
Charges covered for you (co-insurance)	<i>In-Network</i>	<i>Out-of-Network</i>	<i>In-Network</i>	<i>Out-of-Network</i>
Preventive Care	100%	100%	100%	100%
Basic Care	80%	80%	80%	80%
Major Care	0%	0%	50%	50%
Orthodontia	Not Covered		Not Covered	
Annual Maximum Benefit	\$1000	\$1000	\$1000	\$1000
Lifetime Orthodontia Maximum	Not Applicable		Not Applicable	
Dependent Age Limits(Non-Student/Student)	20/26		19/23	

A Sample of Services Covered by Your Plan:

		Option 1: Base <i>Plan pays (on average)</i>		Option 2: Buy up <i>Plan pays (on average)</i>	
		<i>In-network</i>	<i>Out-of-network</i>	<i>In-network</i>	<i>Out-of-network</i>
Preventive Care	Cleaning (prophylaxis)	100%	100%	100%	100%
	Frequency:	Once Every 6 Months		Once Every 6 Months	
	Fluoride Treatments	100%	100%	100%	100%
	Limits:	Under Age 19		Under Age 19	
	Oral Exams	100%	100%	100%	100%
	Sealants (per tooth)	100%	100%	100%	100%
	X-rays	100%	100%	100%	100%
		X-rays other than bitewings in Basic 80%		X-rays other than bitewings in Basic 80%	
Basic Care	Fillings‡	80%	80%	80%	80%
	Simple Extractions	80%	80%	80%	80%
Major Care	Anesthesia*	0%	0%	50%	50%
	Bridges and Dentures	0%	0%	50%	50%
	Inlays, Onlays, Veneers**	0%	0%	50%	50%
	Perio Surgery	0%	0%	50%	50%
	Periodontal Maintenance	0%	0%	50%	50%
	Frequency:	Once Every 6 Months (Standard)		Once Every 6 Months (Standard)	
	Repair & Maintenance of Crowns, Bridges & Dentures	0%	0%	50%	50%
	Root Canal	0%	0%	50%	50%
	Scaling & Root Planing (per quadrant)	0%	0%	50%	50%
	Single Crowns	0%	0%	50%	50%
	Surgical Extractions	0%	0%	50%	50%
	Deferred Services for Future Employees	None		Major Services - 12 Months	

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 filling 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 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
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: 464193

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-I-DG2000 et al.
- **PPO and or 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

Good News! Your Dental Plan Is Even Better Than You Think

Savings on in-Network providers average 30% of what dentists usually charge!

In-network: Benefits are based on a negotiated contracted fee schedule. No balance billing!

Out-of-network: Benefits are based on usual, reasonable, and customary rates for a given area.

NAP & PPO Plan Example:

Network vs. Non-Network Savings* Difference in your out-of-pocket expense: \$61 Benefits for a Root Canal (on a molar)			
Network Care		Non-Network Care	
Typical network dentist fee:	\$665	Average non-network dentist fee:	\$968
Plan Pays:	\$532**	Plan Pays:	\$774**
You Pay:	\$133	You Pay:	\$194
*Savings may be greater or less depending on your dentist's location **Assumes service is covered at an 80% co-insurance level			

More Reasons to Use Network Care

- One of the industry's largest Preferred Provider networks – highly skilled dental professionals at over 128,000 locations.
- Network dentists are easy to locate. Simply use the On-Line DentalGuard Provider Directory at www.GuardianLife.com or call the number on the back of your ID card. If your provider does not participate, Guardian's convenient dentist referral program can help add them to the network!
- No claim forms to complete. Just present your new DentalGuard Preferred Network ID card to the provider.

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.

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:

- Visit www.GuardianAnytime.com and click on **Find a Provider**.
- 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



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





GUARDIAN[®]

It's easy to use your Guardian Dental Benefits

Your dental benefits are designed to save you money and protect your health. Guardian is committed to making it as easy as possible for you to use and understand your dental benefits, with customer service you can depend on. Whether online or over the phone – we are there for you!

www.GuardianAnytime.com

GUARDIAN
ANYTIME[®]

Offering instant access to your Guardian Benefits information

Your Group ID number required to register

Find an in-network dentist

–the best way to save on dental care!

- Simply click on **Find a Provider** and select **PPO**
- Follow the easy steps to search

App available for both
iPhone and Android
smartphones



Download the App at
www.GuardianAnytime.com/mobile

View/print your ID card

No need for an ID card to use your Guardian dental benefits. Simply provide your Group ID number to your dental office at the first visit. However, if you'd like to print out a copy of your ID card, visit the Forms and Materials section of Guardian Anytime – it's fast and easy.

ID CARD OPTIONAL



BUT NOT REQUIRED

Access to an array of tools

Guardian Anytime includes easy to use tools to help understand the value of your benefits. This includes educational articles and the dental cost estimator tool.

Articles



Forms



Tools



Claims



CUSTOMER
RESPONSE UNIT

800-541-7846

Monday – Friday
8:00 AM to 8:30 PM Eastern Time

Speak to a live representative about your benefits, claims inquiries or help using the Guardian Anytime web site.

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Guardian Life, P.O. Box 14319,
Lexington, KY 40512

Please print clearly and mark carefully.

Employer Name: Metro Corp.	Group Plan Number: 464193	Benefits Effective: _____
PLEASE CHECK APPROPRIATE BOX <input type="checkbox"/> Initial Enrollment <input type="checkbox"/> Re-Enrollment <input type="checkbox"/> Add Employee/Dependents <input type="checkbox"/> Drop/Refuse Coverage <input type="checkbox"/> Information Change <input type="checkbox"/> Increase Amount <input type="checkbox"/> Family Status Change		

Class: 1	Division: _____	Subtotal Code: _____	(Please obtain this from your Employer)
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About You: First, MI, Last Name: _____		Social Security Number ____ - ____ - ____	
Address _____ _____	City _____	State _____	Zip _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yy): ____ - ____ - ____	Phone: () - ____ - ____	
Email Address: _____	Are you married or do you have a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of marriage/union: ____ - ____ - ____	
	Do you have children or other dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No	Placement date of adopted child: ____ - ____ - ____	

About Your Job:		Hours worked per week: _____	Job Title: _____
Work Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> 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.

Spouse (First, MI, Last Name) _____ _____ _____ Address/City/State/Zip: _____ _____ Phone: () - ____ - ____	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Child/Dependent 1: _____ _____ _____ Address/City/State/Zip: _____ _____ Phone: () - ____ - ____	<input type="checkbox"/> Add <input type="checkbox"/> Drop Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Child/Dependent 2: _____ _____ _____ Address/City/State/Zip: _____ _____ Phone: () - ____ - ____	<input type="checkbox"/> Add <input type="checkbox"/> Drop Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent

Child/Dependent 3: Address/City/State/Zip: Phone: () - - -	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Child/Dependent 4: Address/City/State/Zip: Phone: () - - -	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent

Drop Coverage: <input type="checkbox"/> Drop Employee <input type="checkbox"/> Drop Dependents The date of withdrawal cannot be prior to the date this form is completed and signed. Last Day of Coverage: ____ - ____ - ____ <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Retirement Last Day Worked: ____ - ____ - ____ <input type="checkbox"/> Other Event: _____ Date of Event: ____ - ____ - ____	Coverage Being Dropped: <input type="checkbox"/> Dental <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)
Loss Of Other Coverage: I and/or my dependents were previously covered under <u>another insurance plan</u> . Loss of coverage was due to: <input type="checkbox"/> Termination of Employment: ____ - ____ - ____ <input type="checkbox"/> Divorce ____ - ____ - ____ <input type="checkbox"/> Death of Spouse ____ - ____ - ____ <input type="checkbox"/> Termination/Expiration of Coverage ____ - ____ - ____ Coverage Lost <input type="checkbox"/> Dental	I have been offered the above coverage(s) and wish to drop enrollment for the following reasons: <input type="checkbox"/> Covered under another insurance plan <input type="checkbox"/> Other _____ (additional information may be required)

Dental Coverage: You must be enrolled to cover your dependents. Check only one box.				
Your Semi-monthly Premium	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
Option 1: Base	<input type="checkbox"/> \$16.86	<input type="checkbox"/> \$33.76	<input type="checkbox"/> \$41.83	<input type="checkbox"/> \$58.70
Option 2: Buy up	<input type="checkbox"/> \$24.31	<input type="checkbox"/> \$48.63	<input type="checkbox"/> \$54.65	<input type="checkbox"/> \$78.96
<input type="checkbox"/> I do not want this coverage. If you do not want this Dental Coverage, please mark all that apply: <input type="checkbox"/> I am covered under another Dental plan <input type="checkbox"/> My spouse is covered under another Dental plan <input type="checkbox"/> My dependents are covered under another Dental plan				

Signature <ul style="list-style-type: none"> • I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage. • I understand that the premium amounts shown above are estimations and are for illustrative purposes only. • 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 applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.
- I attest 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 statements of claim containing any materially, false information or conceals for 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.

The state in which you reside may have a specific state fraud warning. Please refer to the attached Fraud Warning Statements page.

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 OF EMPLOYEE X _____

DATE _____

Enrollment Kit 464193, 0001, EN

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.

Connecticut, Iowa, Kansas, Nebraska, Oregon, and Vermont: 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.

Delaware, Indiana and Oklahoma: 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.

District of Columbia: 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.

Florida: 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.

Kentucky: 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.

Louisiana and Texas: 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.

Maine, Tennessee, Virginia and Washington: 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.

Maryland: 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.

Rhode Island: 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.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: 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 is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. § 638:20

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: 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 civil fines and criminal penalties or denial of insurance benefits.

Ohio: 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.

Pennsylvania: 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.