



GUARDIAN®

Group Number: 00475402

DELTA ADMINISTRATIVE SERVICES LLC

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
- Vision

THIS PAGE INTENTIONALLY LEFT BLANK

**Dental Benefit Summary****Group Number:** 00475402**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? 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!

<http://health.costhelper.com/dental-crown.html>.

With your **PPO** plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist.

Your Dental Plan**PPO**

Your Network is		DentalGuard Preferred	
Calendar year deductible		<i>In-Network</i>	<i>Out-of-Network</i>
Individual		\$50	\$50
Family limit		3 per family	
Waived for		Preventive	Preventive
Charges covered for you (co-insurance)		<i>In-Network</i>	<i>Out-of-Network</i>
Preventive Care		100%	100%
Basic Care		100%	80%
Major Care		60%	50%
Orthodontia		50%	50%
Annual Maximum Benefit		\$1,000	
Maximum Rollover		Yes	
Rollover Threshold		\$500	
Rollover Amount		\$250	
Rollover In-network Amount		\$350	
Rollover Account Limit		\$1,000	
Lifetime Orthodontia Maximum		\$1,000	
Dependent Age Limits		26	

A Sample of Services Covered by Your Plan:

PPO			
Plan pays (on average)			
		In-network	Out-of-network
Preventive Care	Cleaning (prophylaxis)	100%	100%
	Frequency:	Once Every 6 Months	
	Fluoride Treatments	100%	100%
	Limits:	Under Age 14	
	Oral Exams	100%	100%
Basic Care	Sealants (per tooth)	100%	100%
	X-rays	100%	100%
	Fillings‡	100%	80%
Major Care	Simple Extractions	100%	80%
	Anesthesia*	60%	50%
	Bridges and Dentures	60%	50%
	Inlays, Onlays, Veneers**	60%	50%
	Perio Surgery	60%	50%
	Periodontal Maintenance	60%	50%
	Frequency:	Once Every 6 Months (Standard)	
	Repair & Maintenance of Crowns, Bridges & Dentures	60%	50%
	Root Canal	60%	50%
	Scaling & Root Planing (per quadrant)	60%	50%
Orthodontia	Single Crowns	60%	50%
	Surgical Extractions	60%	50%
	Orthodontia	50%	50%
	Limits:	Adults & Child(ren)	

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.

This handout is for illustrative purposes only and is an approximation. If any discrepancies between this handout and your paycheck stub exist, your paycheck stub prevails.

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, which can be found on the first page of your dental benefit summary.

EXCLUSIONS AND LIMITATIONS

Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred Network 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 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



Vision Benefit Summary

Group Number: 00475402

About Your Benefits:

Eye care is a vital component of a healthy lifestyle. With vision insurance, having regular exams and purchasing contacts or glasses is simple and affordable. The coverage is inexpensive, yet the benefits can be significant! Guardian provides rich, flexible plans that allow you to safeguard your health while saving you money. Review your plan options and see why vision insurance may be a great benefit for you.

Visit any doctor with your **Full Feature** plan, but save by visiting any of the 50,000+ locations in the nation's largest vision network.

Your Vision Plan		Full Feature	
Your Network is		VSP Network Signature Plan	
Copay			
Exams Copay		\$ 10	
Materials Copay (waived for elective contact lenses)		\$ 25	
Sample of Covered Services		You pay (after copay if applicable):	
		In-network	Out-of-network
Eye Exams		\$0	Amount over \$46
Single Vision Lenses		\$0	Amount over \$47
Lined Bifocal Lenses		\$0	Amount over \$66
Lined Trifocal Lenses		\$0	Amount over \$85
Lenticular Lenses		\$0	Amount over \$125
Frames		80% of amount over \$120 ¹	Amount over \$47
Contact Lenses (Elective)		Amount over \$120	Amount over \$120
Contact Lenses (Medically Necessary)		\$0	Amount over \$210
Contact Lenses (Evaluation and fitting)		15% off UCR	No discounts
Cosmetic Extras		Avg. 30% off retail price	No discounts
Glasses (Additional pair of frames and lenses)		20% off retail price [^]	No discounts
Laser Correction Surgery Discount		Up to 15% off the usual charge or 5% off promotional price	No discounts
Service Frequencies			
Exams		Every 12 months	
Lenses (for glasses or contact lenses) ^{††}		Every 12 months	
Frames		Every 24 months	
Network discounts (cosmetic extras, glasses and contact lens professional service)		Limitless within 12 months of exam.	
Dependent Age Limits		26	
		Visit www.GuardianAnytime.com and click on "Find a Provider"	

VSP

- ††Benefit includes coverage for glasses or contact lenses, not both.
- [^] For the discount to apply your purchase must be made within 12 months of the eye exam. In addition Full-Feature plans offer 30% off additional prescription glasses and nonprescription sunglasses, including lens options, if purchased on the same day as the eye exam from the same VSP doctor who provided the exam.

- Charges for an initial purchase can be used toward the material allowance. Any unused balance remaining after the initial purchase cannot be banked for future use. The only exception would be if a member purchases contact lenses from an out of network provider, members can use the balance towards additional contact lenses within the same benefit period.

- ¹Extra \$20 on select brands

This handout is for illustrative purposes only and is an approximation. If any discrepancies between this handout and your paycheck stub exist, your paycheck stub prevails.

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.

EXCLUSIONS AND LIMITATIONS

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.

Laser Correction Surgery:

On average, 15% off the usual charge or 5% off promotional price for vision laser surgery. Members' out-of-pocket costs are limited to \$1,800 per eye for LASIK and \$1,500 per eye for PRK.

Laser surgery is not an insured benefit. The surgery is available at a discounted fee. The covered person must pay the entire discounted fee. In addition, the laser surgery discount may not be available in all states.



The Guardian Life Insurance Company of America
And its Affiliates and Subsidiaries

Enrollment/Change Form
Page 1 of 4

GUARDIAN®

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

Please print clearly and mark carefully.

Employer Name: DELTA ADMINISTRATIVE SERVICES LLC	Group Plan Number: 00475402	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:		Social Security Number _____-_____-____	
Address	City	State	Zip
Gender: M F	Date of Birth (mm-dd-yy): ____-____-____	Phone: () ____-____	
Email Address:	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.

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

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

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

Dental Coverage: You must be enrolled to cover your dependents. Check only one box. PPO Employee Only EE & Spouse EE & Spouse & Dependent/Child(ren) Dependent/Child(ren)	I do not want this coverage. If you do not want this Dental Coverage, please mark all that apply: I am covered under another Dental plan My spouse is covered under another Dental plan My dependents are covered under another Dental plan
--	--

Vision Coverage: You must be enrolled to cover your dependents. Check only one box. Full Feature Employee Only EE & Spouse EE & Spouse & Dependent/Child(ren) Dependent/Child(ren)	I do not want this coverage. If you do not want this Vision Coverage, please mark all that apply: I am covered under another Vision plan My spouse is covered under another Vision plan My dependents are covered under another Vision plan
---	--

Signature

An employee's decision to elect Vision or not elect Vision must be retained until the next plan's Open Enrollment period. If the employee elects not to enroll in vision coverage, they are not eligible to enroll until the plan's next Open Enrollment period.

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.

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 00475402, 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, Nebraska, and Oregon: 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.

Kansas: 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 insurance fraud as determined by a court of law.

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 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.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: 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 have violated state law.