ConnectiCare

FlexPOS-CNT-HSA-2000I/4000F-A1-Comb-A Open Access Contract Year Benefit Summary (A)

The individual deductible and out-of-pocket maximum applies if you have coverage only for yourself and not for any dependents. The family deductible and out-of-pocket maximum applies if you have coverage for yourself and one or more eligible dependents. In addition, if you have family coverage, any applicable copayments or coinsurance will not apply to services until the total deductible is met for the family, without regard to how much any one family member has met.

Your ConnectiCare health plan helps you get the care you need. Here are the most frequently used services. Refer to your certificare of coverage on connecticare.com for a complete list of benefits.

Personalized for: East Granby BOE - Teachers

In-Network Preventive Services
These services are no cost to you when you use an **in-network** doctor or facility. Frequency is based on age and gender. For a complete list of preventive services and to find a doctor, refer to connecticare.com.

Getting care within ConnectiCare's network typically costs you less. You may also get care outside of our network; however, your share of the costs will be higher. Out-of-network doctors and facilities do not appear in the "Find a doctor" directory on connecticare.com.

- **Physical**
- **Well woman visit and pap test**
- **More than 25 screenings, including mammograms and colonoscopies**
- **Flu shot**
- **Vaccinations**
- **Certain birth control and other prevention medications**

	In-network member pays	**Out-of-network member pays**
Your deductible Deductible is combined for medical services and prescription drugs Deductible is combined for in and out-of-network	$2,000 Individual $4,000 Family	$2,000 Individual $4,000 Family
Your out-of-pocket maximum Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services	$2,500 Individual $5,000 Family	$5,000 Individual $10,000 Family
Out-of-network reimbursement	Not applicable	Plan will reimburse the coinsurance percentage of the maximum allowable amount
After you have spent the out-of-pocket maximum amount, ConnectiCare will pay 100% of your covered health care expenses for the remainder of the year.		

Screenings	In-network member pays	Out-of-network member pays
Baseline routine mammography (ages 35-39)	No charge	20% coinsurance after plan deductible
Annual routine mammography (age 40 or older)	No charge	20% coinsurance after plan deductible
Annual routine vision exam	No charge	20% coinsurance after plan deductible
Hearing Screenings one exam every year	No charge	20% coinsurance after plan deductible
Allergy testing Unlimited	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Ongoing Care and Sick Visits	**In-network member pays**	**Out-of-network member pays**
Primary care services (includes office and telemedicine services)	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Specialist services (includes office and telemedicine services)	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Gynecologist services	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Maternity and prenatal care visits May not apply to all laboratory and radiology services – refer to your plan documents	No charge	20% coinsurance after plan deductible
Allergy injections Unlimited	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Telemedicine visit (services rendered by a Teladoc® provider) Primary Care – members must be 18 or older	**Primary Care, Mental Health and General Medical Services:** 0% coinsurance after plan deductible **Dermatologists:** 0% coinsurance after plan deductible	20% coinsurance after plan deductible
Retail clinic	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Nutritional Counseling Limit 3 visits per year	0% coinsurance after plan deductible	20% coinsurance after plan deductible

Ongoing Care and Sick Visits	In-network member pays	Out-of-network member pays
Infertility Infertility benefits outlined in the Certificate of Coverage are unlimited, with no age or cycles restrictions	0% copayment/visit (Office visit) after plan deductible 0% copayment/visit (Ambulatory Services Outpatient) after plan deductible 0% copayment per admission (Inpatient Hospital) after plan deductible	20% coinsurance after plan deductible
Lab and Radiology Performed in a hospital, lab or radiology facility	**In-network member pays**	**Out-of-network member pays**
Laboratory services	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Non-advanced radiology X-ray, diagnostic	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Advanced radiology Hospital facility MRI, PET and CAT scan and nuclear cardiology	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Advanced radiology Stand-alone facility MRI, PET and CAT scan and nuclear cardiology	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Sudden and Unexpected Care	**In-network member pays**	**Out-of-network member pays**
Urgent care or other walk-in clinic	0% coinsurance after plan deductible	Same as In-network benefit
Emergency room	0% coinsurance after plan deductible	Same as In-network benefit
Ambulance	0% coinsurance after plan deductible	Same as In-network benefit
Inpatient Hospital Services	**In-network member pays**	**Out-of-network member pays**
Inpatient hospital services, including room and board	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Skilled nursing and rehabilitation facilities up to 120 days per year	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Private duty nursing up to $15,000 per year	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Outpatient Hospital Services and Home Care	**In-network member pays**	**Out-of-network member pays**
Hospital outpatient facilities	0% coinsurance after plan deductible	20% coinsurance after plan deductible

Outpatient Hospital Services and Home Care	**In-network member pays**	**Out-of-network member pays**
Ambulatory surgical center	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Home health services Nursing and therapeutic services limited to 200 visits Home Health aide services limited to 80 visits that are applicable to 200 visit limit	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Outpatient Rehabilitative Services	**In-network member pays**	**Out-of-network member pays**
Rehabilitative Services up to 50 visits per year (includes services combined for physical, speech and occupational therapy and chiropractic services)	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Mental Health and Substance Abuse	**In-network member pays**	**Out-of-network member pays**
Inpatient mental health services	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Inpatient alcohol and substance abuse treatment	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Outpatient mental health, alcohol and substance abuse treatment office visits and home services	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Outpatient mental health, alcohol and substance abuse treatment intensive outpatient treatment and partial hospitalization	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Supplies	**In-network member pays**	**Out-of-network member pays**
Durable medical equipment including prosthetics and disposable medical supplies Includes wigs prescribed by an oncologist for a member suffering hair loss as a result of chemotherapy or radiation therapy up to one wig per year	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Artificial Limbs includes associated supplies and equipment	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Diabetic equipment and supplies	0% coinsurance after plan deductible	20% coinsurance after plan deductible

Supplies	In-network member pays	Out-of-network member pays
Modified food products and specialized formula pharmacy tier	0% coinsurance after plan deductible	20% coinsurance after plan deductible

Important information

- This is a brief summary of benefits. Refer to your ConnectiCare Insurance Company, Inc. Certificate of Coverage for complete details on benefits, conditions, limitations and exclusions, or consult with your benefits manager. All benefits described are per member per Contract year.
- Ovarian cancer screening and monitoring services coverage and cost share details are available in your Certificate of Coverage.
- Mammogram screenings, breast ultrasounds, and breast MRIs - Please refer to the Certificate of Coverage for details.
- To learn more about your Teladoc® provider benefits contact Teladoc® at teladoc.com/connecticare or call 1-800-835-2362 (TTY: 711).
- Insulin and noninsulin drugs are covered up to a cost share maximum of $25 for each 30-day supply.
- Diabetes Devices and Diabetic Ketoacidosis Devices are covered up to a cost share maximum of $100 per 30-day supply.
- Please refer to the certificate of coverage for additional cost share maximums regarding diabetic services. Some diabetic services fall under preventive care and cost share may be waived.
- Certain services require Prior Authorization, please refer to your Certificate of Coverage for a detailed list of services or call member service at 1-800-251-7722.
- If you have questions regarding your plan, visit our website at **www.connecticare.com** or call us at (860) 674-5757 or 1-800-251-7722.
- Out-of-Network reimbursement is based on the maximum allowable amount. Members are responsible to pay any charges in excess of this amount. Please refer to your ConnectiCare Insurance Company, Inc. Certificate of Coverage for more information.
- If you are a Massachusetts resident, please refer to your *amendatory rider for Massachusetts mandated benefits* for additional details of your benefits.
- If you are a Massachusetts resident, this plan along with pharmacy services meets Massachusetts Minimum Creditable Coverage standards for 2023.

ConnectiCare

FlexPOS Combined Deductible Prescription Drug Plan for Use with Health Savings Account (HSA) Benefit Summary

This is a brief summary of your prescription drug benefits. Refer to your prescription drug rider for complete details on benefits, conditions, limitations and exclusions, or consult with your benefits manager. All benefits described below are per member per Contract year.

Personalized for: East Granby BOE - Teachers

Covered prescription drugs through retail participating pharmacies or our mail order service. **Generics are dispensed unless the provider writes "Dispense as Written" on the prescription.** Your Plan includes the following: Mandatory drug substitution, Generic substitution program, Pay the difference waiver, Tiered cost-share program, and Voluntary mail order program.		
	In-network member pays	**Out-of-network member pays**
Your deductible Deductible is combined for medical services and prescription drugs Deductible is combined for In and out-of-network	$2,000 Individual $4,000 Family	$2,000 Individual $4,000 Family
Your out-of-pocket maximum Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services	$2,500 Individual $5,000 Family	$5,000 Individual $10,000 Family
Retail Pharmacy (up to a 30 day supply per prescription)	**In-network member pays**	**Out-of-network member pays**
Generic drugs (Tier 1)	$5 copayment/prescription after plan deductible	50% coinsurance after plan deductible
Preferred brand drugs (Tier 2)	$25 copayment/prescription after plan deductible	50% coinsurance after plan deductible
Non-preferred brand drugs (Tier 3)	$45 copayment/prescription after plan deductible	50% coinsurance after plan deductible
Mail Order Pharmacy (up to a 90 day supply per prescription)	**In-network member pays**	**Out-of-network member pays**
Generic drugs (Tier 1)	$10 copayment/prescription after plan deductible	50% coinsurance after plan deductible

Mail Order Pharmacy (up to a 90 day supply per prescription)	**In-network member pays**	**Out-of-network member pays**
Preferred brand drugs (Tier 2)	$50 copayment/prescription after plan deductible	50% coinsurance after plan deductible
Non-preferred brand drugs (Tier 3)	$90 copayment/prescription after plan deductible	50% coinsurance after plan deductible

Additional information

- Under this program covered prescription drugs and supplies are put into categories (i.e., tiers) to designate how they are to be covered and the member's cost-share. The placement of a drug or supply into one of the tiers is determined by the ConnectiCare Pharmacy Services Department and approved by the ConnectiCare Pharmacy & Therapeutics Committee based on the drug's or supply's clinical effectiveness and cost, not on whether it is a generic drug or supply or brand name drug or supply.
- Amounts paid by members because they must pay a price difference for a brand name drug do not count towards meeting any deductibles, coinsurance and copayment.
- Most specialty drugs are dispensed through specialty pharmacies by mail, up to a 30 day supply. Specialty pharmacies have the same member cost share as all other participating pharmacies and are not part of ConnectiCare's voluntary mail order program. The member cost share for specialty pharmacy is different from the cost share for ConnectiCare's mail order program.
- Insulin and noninsulin drugs are covered up to a cost share maximum of $25 for each 30-day supply.
- Diabetes Devices and Diabetic Ketoacidosis Devices are covered up to a cost share maximum of $100 per 30-day supply.
- Please refer to the prescription drug rider for additional cost share maximums regarding diabetic services. Some diabetic services fall under preventive care and cost share may be waived.
- If you are a Massachusetts resident, please refer to your *amendatory rider for Massachusetts mandated benefits* for additional details of your benefits.

ConnectiCare

Choice HMO-OA-CAL-40-50-450-450A-04 HMO Open Access Calendar Year Plan Benefit Summary

Your ConnectiCare health plan helps you get the care you need. Here are the most frequently used services. Refer to your membership agreement on connecticare.com for a complete list of benefits.

Personalized for: East Granby BOE - Teachers

In-Network Preventive Services
These services are no cost to you when you use an **in-network** doctor or facility. Frequency is based on age and gender. For a complete list of preventive services and to find a doctor, refer to connecticare.com.

- **Physical**
- **Well woman visit and pap test**
- **More than 25 screenings, including mammograms and colonoscopies**
- **Flu shot**
- **Vaccinations**
- **Certain birth control and other prevention medications**

	In-network member pays
Your deductible	$0 Individual $0 Family
Your out-of-pocket maximum Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services	$6,350 Individual $12,700 Family
After you have spent the in-network out-of-pocket maximum amount, ConnectiCare will pay 100% of your covered health care expenses for the remainder of the year.	
Screenings	**In-network member pays**
Baseline routine mammography (ages 35-39)	No charge
Annual routine mammography (age 40 or older)	No charge
Annual routine vision exam	$10 copayment/visit;
Hearing Screenings one exam every year	No charge
Allergy testing Unlimited	Refer to your applicable primary care or specialist cost share
Ongoing Care and Sick Visits	**In-network member pays**
Primary care services (includes office and telemedicine services)	$40 copayment/visit

Ongoing Care and Sick Visits	In-network member pays
Specialist services (includes office and telemedicine services)	$50 copayment/visit
Gynecologist services	$40 copayment/visit
Maternity and prenatal care visits May not apply to all laboratory and radiology services – refer to your plan documents	No charge
Allergy injections Unlimited	No charge
Telemedicine visit (services rendered by a Teladoc® provider) Primary Care – members must be 18 or older	**Primary Care, Mental Health and General Medical Services:** No charge **Dermatologists:** $40 copayment/visit
Retail clinic	$40 copayment/visit
Nutritional Counseling Limit 3 visits per year	No charge
Infertility Infertility benefits outlined in the Certificate of Coverage are unlimited, with no age or cycles restrictions	$50 copayment/visit (Office visit) $450 copayment/visit (Ambulatory Services Outpatient) $450 copayment per admission (Inpatient Hospital)
Lab and Radiology **Performed in a hospital, lab or radiology facility**	**In-network member pays**
Laboratory services	No charge
Non-advanced radiology X-ray, diagnostic	No charge
Advanced radiology **Hospital facility** MRI, PET and CAT scan and nuclear cardiology up to five copayments per year	$75 copayment/service
Advanced radiology **Stand-alone facility** MRI, PET and CAT scan and nuclear cardiology up to five copayments per year	$75 copayment/service

Sudden and Unexpected Care The same cost share applies for both in-network and out-of-network service	**In-network member pays**
Urgent care or other walk-in clinic	$100 copayment/visit
Emergency room copayment waived if admitted	$200 copayment/visit
Ambulance	No charge
Inpatient Hospital Services	**In-network member pays**
Inpatient hospital services, including room and board (copayment maximum is combined with Skilled nursing and rehabilitation services)	$450 copayment per admission
Skilled nursing and rehabilitation facilities up to 120 days per year (copayment maximum is combined with Inpatient hospital services)	$450 copayment per admission
Private duty nursing up to $15,000 per year	No charge
Outpatient Hospital Services and Home Care	**In-network member pays**
Hospital outpatient facilities	$450 copayment/visit
Ambulatory surgical center	$450 copayment/visit
Home health services Nursing and therapeutic services limited to 200 visits Home health aide services limited to 80 visits that are applicable to 200 visit limit	No charge
Outpatient Rehabilitative Services	**In-network member pays**
Rehabilitative Services up to 50 visits per year includes services combined for physical, speech, and occupational therapy and chiropractic services	$30 copayment/visit
Mental Health and Substance Abuse	**In-network member pays**
Inpatient mental health services	$450 copayment per admission
Inpatient alcohol and substance abuse treatment	$450 copayment per admission

Mental Health and Substance Abuse	In-network member pays
Outpatient mental health, alcohol and substance abuse treatment office visits and home services	$40 copayment/visit
Outpatient mental health, alcohol and substance abuse treatment intensive outpatient treatment and partial hospitalization	$40 copayment/visit
Supplies	**In-network member pays**
Durable medical equipment including prosthetics and disposable medical supplies	50% coinsurance
Artificial Limbs includes associated supplies and equipment	20% coinsurance
Diabetic equipment and supplies	20% coinsurance
Modified food products and specialized formula pharmacy tier	50% coinsurance

Getting care outside of our network

Generally your plan does not cover services rendered outside of our network. Please refer to your member documents for additional plan information.

To ensure that you use services within our network, please visit www.connecticare.com and use the "Find a doctor" option to search for doctors and facilities.

Important information

- This is a brief summary of benefits. Refer to your Membership Agreement for complete details on benefits, conditions, limitations and exclusions, or consult with your benefits manager. All benefits described are per member per Calendar year.
- Ovarian cancer screening and monitoring services coverage and cost share details are available in your Membership Agreement.
- Mammogram screenings, breast ultrasounds, and breast MRIs - Please refer to the Membership Agreement for details.
- To learn more about your Teladoc® provider benefits contact Teladoc® at teladoc.com/connecticare or call 1-800-835-2362 (TTY: 711).
- Insulin and noninsulin drugs are covered up to a cost share maximum of $25 for each 30-day supply.
- Diabetes Devices and Diabetic Ketoacidosis Devices are covered up to a cost share maximum of $100 per 30-day supply.
- Please refer to the membership agreement for additional cost share maximums regarding diabetic services. Some diabetic services fall under preventive care and cost share may be waived.
- Certain services require Prior Authorization, please refer to your Membership Agreement for a detailed list of services or call member service at 1-800-251-7722.

- If you have questions regarding your plan, visit our website at www.connecticare.com or call us at (860) 674-5757 or 1-800-251-7722.
- If you are a Massachusetts resident, please refer to your amendatory rider for Massachusetts mandated benefits for additional details of your benefits.
- If you are a Massachusetts resident, this plan along with pharmacy services meet Massachusetts Minimum Creditable Coverage standards for 2023.

ConnectiCare

Prescription Drug Copayment Plan Benefit Summary

This is a brief summary of your prescription drug benefits. Refer to your prescription drug rider for complete details on benefits, conditions, limitations and exclusions, or consult with your benefits manager. All benefits described below are per member per Calendar year.

Personalized for: East Granby BOE - Teachers

Covered prescription drugs through retail participating pharmacies or our mail order service. **Generics are dispensed unless the provider writes "Dispense as Written" on the prescription.** Your Plan includes the following: Mandatory drug substitution, Generic substitution program, Pay the difference waiver, Tiered cost-share program, and Voluntary mail order program.

	In-network member pays
Your out-of-pocket maximum	$6,350 Individual $12,700 Family
Retail Pharmacy (up to a 30 day supply per prescription)	**In-network member pays**
Generic drugs (Tier 1)	$5 copayment/prescription
Preferred brand drugs (Tier 2)	$25 copayment/prescription
Non-preferred brand drugs (Tier 3)	$45 copayment/prescription
Mail Order Pharmacy (up to a 90 day supply per prescription)	**In-network member pays**
Generic drugs (Tier 1)	$10 copayment/prescription
Preferred brand drugs (Tier 2)	$50 copayment/prescription
Non-preferred brand drugs (Tier 3)	$90 copayment/prescription
Getting care outside of our network	
• Your plan does not cover services rendered outside of our network	

Additional information

- Under this program covered prescription drugs and supplies are put into categories (i.e., tiers) to designate how they are to be covered and the member's cost-share. The placement of a drug or supply into one of the tiers is determined by the ConnectiCare Pharmacy Services Department and approved by the ConnectiCare Pharmacy & Therapeutics Committee based on the drug's or supply's clinical effectiveness and cost, not on whether it is a generic drug or supply or brand name drug or supply.
- Most specialty drugs are dispensed through specialty pharmacies by mail, up to a 30 day supply. Specialty pharmacies have the same member cost share as all other participating pharmacies and are not part of ConnectiCare's voluntary mail order program. The member cost share for specialty pharmacy is different from the cost share for ConnectiCare's mail order program.
- Insulin and noninsulin drugs are covered up to a cost share maximum of $25 for each 30-day supply.
- Diabetes Devices and Diabetic Ketoacidosis Devices are covered up to a cost share maximum of $100 per 30-day supply.
- Please refer to the prescription drug rider for additional cost share maximums regarding diabetic services. Some diabetic services fall under preventive care and cost share may be waived.
- If you are a Massachusetts resident, please refer to your amendatory rider for Massachusetts mandated benefits for additional details of your benefits.

Guardian®

Your dental coverage

PPO plan, you'll have access to one of the largest networks of dentists with two reimbursement levels that give you more control over savings. You will always save money with any dentist in Guardian's network and when they belong to a tier in the Tier 1 reimbursement level you will maximize your savings. Reimbursement for covered services received from a non-contracted dentist will be based on a percentile of the prevailing fee data for the dentist's zip code.

Your Dental Plan	**PPO**	
	Tier 1	Tier 2
Your Network is DentalGuard Preferred Network	In-Network	Out-of-Network
Calendar year deductible	*Tier 1*	*Tier 2*
Individual	$25	$25
Family limit	2 per family (applies to all levels)	
Waived for	Preventive	Preventive
Charges covered for you (co-insurance)	*Tier 1*	*Tier 2*
Preventive Care	100%	100%
Basic Care	85%	85%
Major Care	50%	50%
Orthodontia	50%	50%
Annual Maximum Benefit	$2000 (applies to all levels)	
Maximum Rollover	Yes (applies to all levels)	
Rollover Threshold	$800	
Rollover Amount	$400	
Rollover Amount	$600	
Rollover Account Limit	$1500	
Lifetime Orthodontia Maximum	$2000 (applies to all levels)	
Dependent Age Limits	26 (applies to all levels)	

Guardian®

Your dental coverage

A Sample of Services Covered by Your Plan:

		PPO *Plan pays (on average)*	
		Tier 1	Tier 2
Preventive Care	Cleaning (prophylaxis)	100%	100%
	Frequency:	Once Every 6 Months (applies to all levels)	
	Fluoride Treatments	100%	100%
	Limits:	Under Age 16 (applies to all levels)	
	Oral Exams	100%	100%
	Sealants (per tooth)	100%	100%
	X-rays	100%	100%
Basic Care	Anesthesia*	85%	85%
	Fillings‡	85%	85%
	Perio Surgery	85%	85%
	Periodontal Maintenance	85%	85%
	Frequency:	Once Every 6 Months (applies to all levels)	
	Root Canal	85%	85%
	Scaling & Root Planing (per quadrant)	85%	85%
	Simple Extractions	85%	85%
	Surgical Extractions	85%	85%
Major Care	Bridges and Dentures	50%	50%
	Dental Implants	50%	50%
	Inlays, Onlays, Veneers**	50%	50%
	Repair & Maintenance of Crowns, Bridges & Dentures	50%	50%
	Single Crowns	50%	50%
Orthodontia	Orthodontia	50%	50%
	Limits:	Child(ren) (applies to all levels)	

Guardian's Preferred Provider Organization consists of Dentists in the DentalGuard Preferred ("DGP") network. These tiers represent specific benefit levels as described in Your Schedule of Benefits. Network access varies by geographic location and zip code. Please visit www.Guardianlife.com to confirm your Dentist's tiered participation.

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. *General Anesthesia – restrictions apply. ‡For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings.

Guardian

Your dental coverage

Manage Your Benefits:

Go to www.Guardianlife.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.Guardianlife.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.

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: 00051769

Please call the Guardian Helpline if you need to use your benefits within 30 days of plan effective date. Please note, self-serve options over the phone or online at Guardian Anytime are not available until the case is fully implemented, please wait to speak to a live agent when calling the Guardian Helpline.

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 # DG7-P 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-DG7

DentalGuard Insurance is underwritten and issued by The Guardian Life Insurance Company of America, 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. This policy provides DENTAL insurance only.
Policy Form # GP-1-DG2000, et al, GP-1-DEN-16

Guardian

Watch our video
How life insurance protects families and covers critical costs.

Life insurance

If something happens to you, life insurance can help your family reduce financial stress.

Life insurance helps protect your family's finances by providing a cash benefit if you pass away. This ensures that they'll be financially supported, and can cover important things from bills to funeral costs. With life policies, you can get affordable life insurance protection for a set period of time.

Who is it for?

Everyone's life insurance needs are different, depending on their family situation. That's why group life insurance through an employer is an easier and more affordable option than individual life insurance.

What does it cover?

Life insurance protects your loved ones by providing a benefit (which is usually tax-exempt) if you pass away.

Why should I consider it?

Life insurance is about more than just covering expenses. Depending on your circumstances, it could take your family years to recover from the loss of your income.

With a life insurance benefit, your family will have extra money to cover mortgage and rent payments, legal or medical fees, childcare, tuition, and any outstanding debts.

Guardian, its subsidiaries, agents, and employees do not provide tax, legal, or accounting advice. Consult your tax, legal, or accounting professional regarding your individual situation.

You will receive these benefits if you meet the conditions listed in the policy.

Preparing and planning

Jorge's never considered purchasing life insurance, but after being offered it through work, he decides it's a smart way to protect his family.

Jorge has a mortgage, and because his wife is helping to take care of her mother, she only works part-time. In addition, his daughter is about to start college.

Jorge looks at how his family would be affected by losing him.

Average funeral cost: **$9,000**

Average mortgage debt: **$202,000**

Average cost of college: **$17,000 - $44,000**

Average household credit card debt: **$8,500**

With life insurance, Jorge can make sure that part of these costs are covered if something happens to him.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.

Guardian

Your life coverage

	BASIC LIFE
Employee Benefit	Your employer provides Basic Life Coverage for all full time employees in the amount of 175% of your annual salary, to a maximum of $275,000.
Accidental Death and Dismemberment	Your Basic Life coverage includes Enhanced Accidental Death and Dismemberment coverage.
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when you sign up for coverage during the initial enrollment period.	Guarantee Issue coverage up to $275,000 per employee
Premiums	Covered by your company if you meet eligibility requirements
Portability: Allows you to take coverage with you if you terminate employment.	Yes, with age and other restrictions, including evidence of insurability
Conversion: Allows you to continue your coverage after your group plan has terminated.	Yes, with restrictions; see certificate of benefits
Accelerated Life Benefit: A lump sum benefit is paid to you if you are diagnosed with a terminal condition, as defined by the plan.	Yes
Waiver of Premiums: Premium will not need to be paid if you are totally disabled.	For employees disabled prior to age 60, with premiums waived until age 70, if conditions are met
Benefit Reductions: Benefits are reduced by a certain percentage as an employee ages.	33% at age 70, 55% at age 75

Subject to coverage limits

The Guarantee Issue amount may be subject to reductions by percentage at the ages shown in this summary.

Guardian®

Your life coverage

LIMITATIONS AND EXCLUSIONS:

A SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS FOR LIFE AND AD&D COVERAGE:

You must be working full-time on the effective date of your coverage; otherwise, your coverage becomes effective after you have completed a specific waiting period. Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding one year; or (b) in an area under travel warning by the US Department of State. Subject to state specific variations. Evidence of Insurability is required on all late enrollees. This coverage will not be effective until approved by a Guardian underwriter. This proposal is hedged subject to satisfactory financial evaluation. Please refer to certificate of coverage for full plan description.

Accelerated Life Benefit is not paid to an employee under the following circumstances: one who is required by law to use the benefit to pay creditors; is required by court order to pay the benefit to another person; is required by a government agency to use the payment to receive a government benefit; or loses his or her group coverage before an accelerated benefit is paid.

For AD&D: We pay no benefits for any loss caused: by willful self-injury; sickness, disease or medical treatment; by participating in a civil disorder or committing a felony; Traveling on any type of aircraft while having duties er on that aircraft; by declared or undeclared act of war or armed aggression; while a member of any armed force (May vary by state); while driving a motor vehicle without a current, valid driver's license; by legal intoxication; or by voluntarily using a non-prescription controlled substance. Contract #GP-1-R-ADCL1-00 et al. We won't pay more than 100% of the Insurance amount for all losses due to the same accident, except as stated. The loss must occur within a specific period of time of the accident. Please see contract for specific definition; definition of loss may vary depending on the benefit payable.

GP-1-R-LB-90

Enhanced AD&D: A loss may be defined as death, quadriplegia, loss of speech and hearing, loss of cognitive function, comatose state in excess of one month, hemiplegia or paraplegia. The loss must occur within a specific period of time of the accident. Please see contract for specific definition; definition of loss may vary depending on the benefit payable.

Guardian Group Life Insurance underwritten and issued by The Guardian Life Insurance Company of America, 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-LIFE-15

Guardian

Watch our video
How long term disability insurance can supplement your income.

Long term disability insurance

Disability insurance covers a part of your income, so you can pay your bills if you're injured or sick and can't work.

Disability may be more common than you might realize, and people can be unable to work for all sorts of different reasons. There are times when many disabilities can be caused by illness, including common conditions like heart disease and arthritis. However, many disabilities aren't covered by workers' compensation.

Who is it for?

If you rely on your income to pay for everyday expenses, then you should probably consider disability insurance. It helps ensure that you'll receive a partial income if you're injured or too sick to work.

What does it cover?

Many disability insurance plans pay out a portion or percentage of your income if you're diagnosed with a serious illness or experience an injury that prevents you from doing your job.

Why should I consider it?

Accidents happen, and you can't always anticipate if or when you'll become sick or injured. That's why it's important to have a disability policy that helps you pay your bills in the event of being unable to collect your normal paycheck.

Partial income replacement

Jim suffers a heart attack that leaves him unable to work for two years.

Unpaid time off work: **24 months**

Elimination period: **6 months**

After a 6 month elimination period, Jim's Guardian Long Term Disability policy kicks in and replaces **$2,000** of his monthly income for the remaining **18 months** of his disability or illness.

This gives him a total of **$36,000** to cover his expenses while he's unable to work.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.

You will receive these benefits if you meet the conditions listed in the policy.

Guardian®

Your long term disability coverage

	Long-Term Disability
Coverage amount	60% of salary to maximum $4000/month
Maximum payment period: Maximum length of time you can receive disability benefits.	Social Security Normal Retirement Age
Accident benefits begin: The length of time you must be disabled before benefits begin.	Day 181
Illness benefits begin: The length of time you must be disabled before benefits begin.	Day 181
Conversion: Allows you to continue disability coverage after your group plan has terminated.	Yes
Evidence of Insurability: A health statement requiring you to answer a few medical history questions.	Health Statement may be required
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when applicant signs up for coverage during the initial enrollment period.	We Guarantee Issue $4000 in coverage
Minimum work hours/week: Minimum number of hours you must regularly work each week to be eligible for coverage.	Planholder Determines
Pre-existing conditions: A pre-existing condition includes any condition/symptom for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	3 months look back; 12 months after exclusion
Survivor benefit: Additional benefit payable to your family if you die while disabled.	3 months

UNDERSTANDING YOUR BENEFITS—DISABILITY (Some information may vary by state)

- **Disability (long-term):** For first five years of disability, you will receive benefit payments while you are unable to work in your own occupation. After five years, you will continue to receive benefits if you cannot work in any occupation based on training, experience and education.
- **Earnings definition:** Your covered salary is based on your previous year's W2 statement.
- **Special limitations:** Provides a 24-month benefit limit for specific conditions including mental health and substance abuse. Other conditions such as chronic fatigue are also included in this limitation. Refer to contract for details.
- **Work incentive:** Plan benefit will not be reduced for a specified amount of months so that you have part-time earnings while you remain disabled, unless the combined benefit and earnings exceed 100% of your previous earnings.

Guardian®

Your long term disability coverage

A SUMMARY OF DISABILITY PLAN LIMITATIONS AND EXCLUSIONS

- Evidence of Insurability may be required on all late enrollees. This coverage will not be effective until approved by a Guardian underwriter. This proposal is hedged subject to satisfactory financial evaluation. Please refer to certificate of coverage for full plan description.
- You must be working full-time on the effective date of your coverage; otherwise, your coverage becomes effective after you have completed a specific waiting period.
- Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding one year; or (b) in an area under travel warning by the US Department of State. Subject to state specific variations.
- For Long-Term Disability coverage, we pay no benefits for a disability caused or contributed to by a pre-existing condition unless the disability starts after you have been insured under this plan for a specified period of time. We limit the duration of payments for long term disabilities caused by mental or emotional conditions, or alcohol or drug abuse.
- We do not pay benefits for charges relating to a covered person: taking part in any war or act of war (including service in the armed forces) committing a felony or taking part in any riot or other civil disorder or intentionally injuring themselves or attempting suicide while sane or insane. We do not pay benefits for charges relating to legal intoxication, including but not limited to the operation of a motor vehicle, and for the voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless it has been prescribed by a doctor and is used as prescribed. We limit the duration of payments for long term disabilities caused by mental or emotional conditions, or alcohol or drug abuse. We do not pay benefits during any period in which a covered person is confined to a correctional facility, an employee is not under the care of a doctor, an employee is receiving treatment outside of the US or Canada, and the employee's loss of earnings is not solely due to disability.
- This policy provides disability income insurance only. It does not provide "basic hospital", "basic medical", or "medical" insurance as defined by the New York State Insurance Department.
- If this plan is transferred from another insurance carrier, the time an insured is covered under that plan will count toward satisfying Guardian's pre-existing condition limitation period. State variations may apply.
- When applicable, this coverage will integrate with NJ TDB, NY DBL, CA SDI, RI TDI, Hawaii TDI and Puerto Rico DBA, DC PFML and WA PFML.

Contract # GP-1-LTD-15-1.0 et al.

Guardian's Group Long Term Disability Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. This policy provides disability income insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services. Plan documents are the final arbiter of coverage.
Policy Form #GP-1-LTD07-1.0, et al, GP-1-LTD-15

Guardian®

Employee Assistance Program

We all need a little support every now and then.

Guardian's Employee Assistance Program gives you and your family members access to confidential personal support, across everything from stress management and nutrition to handling legal or financial issues.

The services available include consultations with experienced professionals, as well as access to resources and discounts designed to help you in a variety of different ways.

How it can help

Consultative services are available to provide direct support and assistance

Work/life assistance that can help you save money and balance commitments

Access legal and financial assistance and resources – including WillPrep Services

How to access

To access the WorkLifeMatters Employee Assistance Program, you'll need a few personal details.

Visit
worklife.uprisehealth.com

Access Code
worklife

For more information or support, you can reach out by phoning **1 800 386 7055**. The team is available 24 hours a day, 7 days a week[1].

This service is only available if you purchase qualifying lines of coverage. See your plan administrator for more details.

WorkLifeMatters Program services are provided by Uprise Health, and its contractors. Guardian does not provide any part of WorkLifeMatters program services. Guardian is not responsible or liable for care or advice given by any provider or resource under the program. This information is for illustrative purposes only. It is not a contract. Only the Administration Agreement can provide the actual terms, services, limitations and exclusions. Guardian and Uprise Health reserve the right to discontinue the WorkLifeMatters program at any time without notice. Legal services provided through WorkLifeMatters will not be provided in connection with or preparation for any action against Guardian, Uprise Health, or your employer. WorkLifeMatters Program is not an insurance benefit and may not be available in all states.

[1]Office hours: Monday-Friday 6 a.m.–5 p.m. PST.

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