



**LANCASTERS CUSTOM DOCK & LIFT SYSTEMS  
INC**  
ALL ELIGIBLE EMPLOYEES  
Group Number: 00038766



**Customer Service (888) 600-1600**  
Monday to Friday | 8am to 8:30pm ET

## Welcome to

# Workplace benefits

## Everyone deserves a Guardian

Every day, Guardian gives 26 million Americans the security they deserve through our insurance and wealth management products and services.

We've partnered with your organization to offer you a range of employee benefits. Inside this pack, you'll find the plans your employer thinks you might benefit from.

## Your coverage options



**Dental  
insurance**

Taking care of teeth and  
overall health

## Know your benefits

Your benefits support your physical and financial wellbeing, to help keep you and your loved ones protected.

With Guardian, you're in good hands. We've been delivering on our promises for over 150 years, and we're looking forward to doing the same for you too.

**1**

Read through this information.

**2**

Find out more about your benefits.

**3**

Talk to your employer if you need help or have any questions.

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This document is a summary of the major features of the insurance coverage that's been agreed to with your employer – it isn't your contract.

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# Dental insurance

Taking care of your teeth is about more than just covering cavities and cleanings. It also means accounting for more expensive dental work, and your overall health.

With dental insurance, routine preventive care can lead to better overall health. And you'll be able to save money if any extensive dental work is required.

## Who is it for?

Everyone should have access to great dental coverage, which is why we offer comprehensive plans that are available through employers as part of your benefit offerings.

## What does it cover?

Dental insurance helps to protect your overall oral care. That includes services like preventive cleanings, x-rays, restorative services like fillings, and other more serious forms of oral surgery if you ever need them.

## Why should I consider it?

Poor oral health isn't just aesthetic; it's also been linked to conditions including diabetes, heart disease, and strokes. So, while brushing and flossing every day can help keep your teeth clean, nothing should replace regular visits to the dentist.



## Staying healthy

Joe visits his dentist for a routine dental cleaning, to take care of his teeth as well as his overall health.

Oral health is about more than just teeth and gums. It's also essential for a range of other health and wellbeing reasons:

**Cardiovascular disease:** Some research suggests that heart disease, clogged arteries, and infections may be linked to inflammation and infections from oral bacteria.

**Osteoporosis:** Weak and brittle bones may be linked to tooth loss.

**Diabetes:** Research shows that people with gum disease find it more difficult to control their blood sugar levels.

**Alzheimer's disease:** Tooth loss before the age of 35 may be a risk factor for Alzheimer's disease.

All information contained here is from the Mayo Clinic, Oral Health: A Window to Your Overall Health, [www.mayoclinic.com](http://www.mayoclinic.com). 2018.

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



# Your dental coverage

**PPO** plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist. Out-of-network benefits are based on a percentile of the prevailing fee data for the dentist's zip code.

Your Dental Plan		PPO	
Your Network is		DentalGuard Preferred	
Your Bi-weekly premium		\$15.27	
You and Spouse		\$31.00	
You and Child(ren)		\$39.82	
You, Spouse and Child(ren)		\$59.32	
Calendar year deductible		In-Network	Out-of-Network
Individual		\$0	\$50
Family limit		3 per family	
Waived for		Not applicable	Preventive
Charges covered for you (co-insurance)		In-Network	Out-of-Network
Preventive Care		100%	100%
Basic Care		80%	80%
Major Care		50%	50%
Orthodontia		Not Covered (applies to all levels)	
Annual Maximum Benefit		\$1000	
Maximum Rollover		Yes	
Rollover Threshold		\$500	
Rollover Amount		\$250	
Rollover In-network Amount		\$350	
Rollover Account Limit		\$1000	
Lifetime Orthodontia Maximum		Not Applicable	
Dependent Age Limits		26	



# Your dental coverage

## 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%
	Sealants (per tooth)	100%	100%
	X-rays	100%	100%
Basic Care	Fillings†	80%	80%
Major Care	Anesthesia*	50%	50%
	Bridges and Dentures	50%	50%
	Dental Implants	50%	50%
	Inlays, Onlays, Veneers**	50%	50%
	Perio Surgery	50%	50%
	Periodontal Maintenance	50%	50%
	Frequency:	Once Every 6 Months	
	Repair & Maintenance of Crowns, Bridges & Dentures	50%	50%
	Root Canal	50%	50%
	Scaling & Root Planing (per quadrant)	50%	50%
	Simple Extractions	50%	50%
	Single Crowns	50%	50%
	Surgical Extractions	50%	50%

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

### Manage Your Benefits:

Go to [www.Guardianlife.com](http://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](http://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.



# Your dental coverage

## 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

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

# Oral Health Rewards Program

Regular visits to the dentist can help prevent and detect the early signs of serious diseases.

That's why Guardian's Maximum Rollover Oral Health Rewards Program encourages and rewards members who visit the dentist, by rolling over part of your unused annual maximum into a Maximum Rollover Account (MRA). This can be used in future years if your plan's annual maximum is reached.



## Automatic rollover

Submit a claim (without exceeding the paid claims threshold of a benefit year), and Guardian will roll over a portion of your unused annual dental maximum.

## How maximum rollover works \*

Depending on a plan's annual maximum, if claims made for a certain year don't reach a specified threshold, then the set maximum rollover amount can be rolled over.

Plan annual maximum**	Threshold	Maximum rollover amount	In-network only rollover amount	Maximum rollover account limit
<b>\$1,000</b>	<b>\$500</b>	<b>\$250</b>	<b>\$350</b>	<b>\$1,000</b>
Maximum claims reimbursement	Claims amount that determines rollover eligibility	Additional dollars added to a plan's annual maximum for future years	Additional dollars added if only in-network providers were used during the benefit year	The limit that cannot be exceeded within the maximum rollover account

\* This example has been created for illustrative purposes only.

\*\* If a plan has a different annual maximum for PPO benefits vs. non-PPO benefits, (\$1500 PPO/\$1000 non-PPO for example) the non-PPO maximum determines the Maximum Rollover plan. May not be available in all states. Guardian's Dental 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. Information provided in this communication is for informational purposes only. Dental Policy Form No. GP-1-DEN-16. GUARDIAN® is a registered service mark of The Guardian Life Insurance Company of America © Copyright 2019 The Guardian Life Insurance Company of America.

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2020-105050 (07/22)

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# Our commitment to you

Please read the documentation referenced below carefully. The notices are intended to provide you important information about our insurance offerings and to protect your interests. Certain ones are required by law.

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## Important information



### **Notice Informing Individuals about Nondiscrimination and Accessibility Requirements**

Guardian notice stating that it complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, sex, or actual or perceived gender identity. The notice provides contact information for filing a nondiscrimination grievance. It also provides contact information for access to free aids and services by disabled people to assist in communications with Guardian.

Visit <https://www.guardiananytime.com/notice48> to read more.

### **No Cost Language Services**

Guardian provides language assistance in multiple languages for members who have limited English proficiency.

Visit <https://www.guardiananytime.com/notice46> to read more.

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## Dental insurance



### **Guardian's HIPAA Notice of Privacy Practices**

The notice describes how health information about you may be used and disclosed and how you can access this information. Visit <https://www.guardiananytime.com/notice50> to read more.

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

Please print clearly and mark carefully.

Employer/Planholder Name: **LANCASTER'S CUSTOM DOCK & LIFT SYSTEMS INC**

Group Plan Number: **00038766**

Benefits Effective: \_\_\_\_\_

PLEASE CHECK APPROPRIATE BOX    ☐ Initial Enrollment    ☐ Add Employee/Member Dependents/Family Members    ☐ Drop/Refuse Coverage    ☐ Information Change

In this form, you will be referred to as an Employee/Member. Members of your family will be referred to as Dependents/Family Members. There will also be times, when referring to Dependents/Family Members, this form will distinguish between your spouse and your children. Depending on the type of plan your Planholder selected, other plan documents may refer to you as an employee, a member, or a similar term, and, to members of your family, as family members, dependents, eligible dependents, or a similar term. Please refer to the group policy, certificate of coverage, (sometimes called a member guide), to see how terms are defined and to determine which members of your family are eligible for coverage. Plan documents such as the group policy, certificate of coverage, (sometimes called a member guide), control if there is any dispute concerning the meaning of terms used in this form.

Class: _____	Division: _____	Subtotal Code: _____	(Please obtain this from your Employer/Planholder)
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**About You:**

Full Legal Name-First, MI, Last Name: \_\_\_\_\_

Employer/Planholder Provided Identification: \_\_\_\_\_

Social Security Number \_\_\_\_\_

What is the name you go by? (optional) \_\_\_\_\_

Your Social Security Number must be provided if enrolling for Life Coverage. Short Term Disability Coverage and/or Long Term Disability Coverage.

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

Gender Identity: ☐ M ☐ F      Date of Birth (mm-dd-yy): \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Phone (indicate primary): ☐ Home (\_\_\_\_) \_\_\_\_ - \_\_\_\_

☐ Work (\_\_\_\_) \_\_\_\_ - \_\_\_\_

☐ Mobile (\_\_\_\_) \_\_\_\_ - \_\_\_\_

E mail Address (indicate primary) ☐ Home \_\_\_\_\_ ☐ Work \_\_\_\_\_

Are you married or in a civil union? ☐ Yes ☐ No  
Do you have children or other dependents? ☐ Yes ☐ No

Date of marriage/civil union: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Placement date of adopted child: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**About Your Job:**

Job Title: \_\_\_\_\_

Work Status:

☐ Active    ☐ Retired    ☐ COBRA/State Continuation

Hours worked per week: \_\_\_\_\_

Date of full time hire: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**About Your Family: Please include the names of the dependents you wish to enroll for coverage.**

Spouse (wherever the term "Spouse" appears on this form, it also includes "Civil Union Partner").

Gender Identity: ☐ M ☐ F

Social Security Number \_\_\_\_\_

Address/City/State/Zip: \_\_\_\_\_

Date of Birth (mm-dd-yyyy) \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Phone: (    )    -    \_\_\_\_\_

Child/Foster Child/Dependent 1: Address/City/State/Zip: _____ Phone: (    )    - _____	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____ Placement date of adopted/ foster child ____ - ____ - ____	Status (check as applicable) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent State of Residence: _____
Child/Foster Child/Dependent 2: Address/City/State/Zip: _____ Phone: (    )    - _____	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____ Placement date of adopted/ foster child ____ - ____ - ____	Status (check as applicable) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent State of Residence: _____
Child/Foster Child/Dependent 3: Address/City/State/Zip: _____ Phone: (    )    - _____	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____ Placement date of adopted/ foster child ____ - ____ - ____	Status (check as applicable) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent State of Residence: _____
Child/Foster Child/Dependent 4: Address/City/State/Zip: _____ Phone: (    )    - _____	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____ Placement date of adopted/ foster child ____ - ____ - ____	Status (check as applicable) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent State of Residence: _____

<b><u>Drop Coverage:</u></b> <input type="checkbox"/> Drop Employee/Member <input type="checkbox"/> Drop Dependents/Family Members 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: ____ - ____ - ____	<b><u>Coverage Being Dropped:</u></b> <input type="checkbox"/> Dental <input type="checkbox"/> Employee/Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)
<b><u>Loss Of Other Coverage:</u></b> I and/or my dependents were previously covered under Loss of coverage was due to: <input type="checkbox"/> Termination of Employment: ____ - ____ - ____ <input type="checkbox"/> Divorce/Separation    ____ - ____ - ____ <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/family members. Check only one box.

Your Bi-weekly Premium      Employee/Member      Employee/Member      Employee/Member, Spouse  
Only      & Spouse      Dependent/Child(ren)      & Dependent/Child(ren)

PPO      ☐ \$15.27      ☐ \$31.00      ☐ \$39.82      ☐ \$59.32

☐ I do not want Dental Coverage because (Check as applicable):

☐ I am covered under another Dental plan

☐ My spouse is covered under another Dental plan

☐ My dependents/family members are covered under another Dental plan

**Signature**

- I understand that my dependents/family members cannot be enrolled for a coverage if I am not enrolled for that coverage.
- 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.
- 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.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements.
- I agree that my employer/planholder may deduct premiums from my pay if they are required for the coverage I have chosen above.
- 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.

SIGNATURE OF EMPLOYEE/MEMBER X \_\_\_\_\_

DATE \_\_\_\_\_

SIGNATURE OF SPOUSE X \_\_\_\_\_

DATE \_\_\_\_\_

SIGNATURE OF CHILD (IF AGE 18 OR OVER ) X \_\_\_\_\_

DATE \_\_\_\_\_

**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.

**California:** For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**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.

**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.

**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.

**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 OF 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.

**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.

**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.

**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.