



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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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 strokes 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: Worsening oral health is seen as Alzheimer's disease progresses.

All information contained here is from the Mayo Clinic, Oral Health: A Window to Your Overall Health, www.mayoclinic.com. 2021.

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



Your dental coverage

Option 1 or 2: BASE PLAN or BUYUP PLAN 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	Option 1: BASE PLAN		Option 2: BUYUP PLAN	
Your Network is	DentalGuard Preferred		DentalGuard Preferred	
Calendar year deductible	<i>In-Network</i>	<i>Out-of-Network</i>	<i>In-Network</i>	<i>Out-of-Network</i>
Individual	\$0	\$50	\$0	\$0
Family limit	3 per family		Not Applicable	
Waived for	Not applicable	None	Not applicable	Not applicable
Charges covered for you (co-insurance)	<i>In-Network</i>	<i>Out-of-Network</i>	<i>In-Network</i>	<i>Out-of-Network</i>
Preventive Care	100%	100%	100%	100%
Basic Care	80%	80%	80%	80%
Major Care	0%	0%	50%	50%
Orthodontia	Not Covered (applies to all levels)		50%	50%
Annual Maximum Benefit	\$1500		\$1500	
Maximum Rollover	Yes		Yes	
Rollover Threshold	\$700		\$700	
Rollover Amount	\$350		\$350	
Rollover In-network Amount	\$500		\$500	
Rollover Account Limit	\$1250		\$1250	
Lifetime Orthodontia Maximum	Not Applicable		\$2000	
Dependent Age Limits	26 *		26 *	

***Family coverage** for spouse and children if the child is dependent upon the employee for support and is: (i) living in the employee's household; or (ii) a full-time or part-time student.



Your dental coverage

A Sample of Services Covered by Your Plan:

		Option 1: BASE PLAN		Option 2: BUYUP PLAN	
		<i>Plan pays (on average)</i>		<i>Plan pays (on average)</i>	
		<i>In-network</i>	<i>Out-of-network</i>	<i>In-network</i>	<i>Out-of-network</i>
Preventive Care	Cleaning (prophylaxis)	100%	100%	100%	100%
	Frequency:	2 per calendar year		2 per calendar year	
	Fluoride Treatments	100%	100%	100%	100%
	Limits:	Under Age 19		Under Age 19	
	Oral Exams	100%	100%	100%	100%
	Sealants (per tooth)	100%	100%	100%	100%
	X-rays	100%	100%	100%	100%
Basic Care	Anesthesia*	80%	80%	80%	80%
	Fillings‡	80%	80%	80%	80%
	Perio Surgery	80%	80%	80%	80%
	Periodontal Maintenance	80%	80%	80%	80%
	Frequency:	Once Every 6 Months		Once Every 6 Months	
	Repair & Maintenance of Crowns, Bridges & Dentures	80%	80%	80%	80%
	Root Canal	80%	80%	80%	80%
	Scaling & Root Planing (per quadrant)	80%	80%	80%	80%
	Simple Extractions	80%	80%	80%	80%
	Surgical Extractions	80%	80%	80%	80%
Major Care	Bridges and Dentures	0%	0%	50%	50%
	Inlays, Onlays, Veneers**	0%	0%	50%	50%
	Single Crowns	0%	0%	50%	50%
Orthodontia	Orthodontia	Not Covered		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. *General Anesthesia – restrictions apply. ‡For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings.



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.

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-I-DG2000 et al.

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
\$1,500 Maximum claims reimbursement	\$700 Claims amount that determines rollover eligibility	\$350 Additional dollars added to a plan’s annual maximum for future years	\$500 Additional dollars added if only in-network providers were used during the benefit year	\$1,250 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 2023 The Guardian Life Insurance Company of America.

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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.

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.

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: THE MOSAIC COMPANY	Group Plan Number: 00563342	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: _____ What is the name you go by? (optional) _____	Employer/Planholder Provided Identification: _____	Social Security Number _____ - _____ - _____ 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 (____) ____ - ____			
Email Address (indicate primary) ☐ Home _____ ☐ Work _____			
Are you married or in a civil union? ☐ Yes ☐ No Date of marriage/civil union: ____ - ____ - ____ Do you have children or other dependents? ☐ Yes ☐ No 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/Family Members you wish to enroll. You can enroll only those Dependents/Family Members that are eligible for coverage. Please refer to the plan documents such as the group policy, member guide, or certificate to determine if a Dependent/Family Member is eligible for coverage.			
If additional space is needed, please attach a separate page with this information along with your enrollment form. Each Dependent/Family Member's Social Security Number must be provided if enrolling them for Life Coverage. Be sure to sign and date (mm-dd-yyyy) the paper and keep a copy for your records. Additional information may be required for non-standard dependents such as a niece or a nephew.			
Spouse	Gender Identity:	Social Security Number	
Address/City/State/Zip: _____	☐ M ☐ F	_____ - _____ - _____	
Phone: () - _____		Date of Birth (mm-dd-yyyy)	
		_____ - ____ - ____	

Child/Dependent 1: Address/City/State/Zip: Phone: () -	☐ Add ☐ Drop	Gender Identity: ☐ M ☐ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent
Child/Dependent 2: Address/City/State/Zip: Phone: () -	☐ Add ☐ Drop	Gender Identity: ☐ M ☐ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent
Child/Dependent 3: Address/City/State/Zip: Phone: () -	☐ Add ☐ Drop	Gender Identity: ☐ M ☐ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent
Child/Dependent 4: Address/City/State/Zip: Phone: () -	☐ Add ☐ Drop	Gender Identity: ☐ M ☐ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent

Drop Coverage: ☐ Drop Employee/Member ☐ Drop Dependents/Family Members 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/Member ☐ Spouse ☐ Child(ren) ☐ Basic Term Life ☐ Voluntary Term Life
Loss Of Other Coverage: I and/or my dependents were previously covered under Loss of coverage was due to: ☐ Termination of Employment: ____ - ____ - ____ ☐ Divorce/Separation ____ - ____ - ____ ☐ Death of Spouse ____ - ____ - ____ ☐ Termination/Expiration of Coverage ____ - ____ - ____ Coverage Lost ☐ Dental	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/family members. Check only one box.				
	Employee/Member Only	Employee/Member & Spouse	Employee/Member & Dependent/Child(ren)	Employee/Member, Spouse & Dependent/Child(ren)
Option 1: BASE PLAN	☐	☐	☐	☐
Option 2: BUYUP PLAN	☐	☐	☐	☐
☐ 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. - I understand that plan design limitations and exclusions may apply. For complete details of coverage, please refer to the plan documents or enrollment materials. State limitations may apply.
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- 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 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.

SIGNATURE OF EMPLOYEE/MEMBER X _____

DATE _____

