YOUR
GROUP INSURANCE
PLAN

SANTA CLARA UNIVERSITY
CLASS 0001
DENTAL

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001
(212) 598-8000
www.GuardianAnytime.com

If Your Group Certificate includes any of the following coverages: Guardian Insured: Group Accident, Group Cancer, Group Critical Illness, Group Hospital Indemnity, Group Dental or Group Vision, the following consumer complaint notice is applicable. (Employer Funded Coverages, if any, are excluded from this Rider.)

New Mexico Residents
Consumer Complaint Notice

If You are a resident of New Mexico, Your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If You have concerns regarding a claim, premium, or other matters relating to this coverage, You may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI) using the complaint form available on the OSI website and found at:

httsp://www.osi.stat.nm.us/ConsumerAssistance/index.aspx

CCN-2019-NM B999.0042

Important Notices

Employer-funded benefits - not insured by Guardian

This Member Guide explains the coverage your planholder offers. It explains the benefits available, as well as the requirements and limits of this coverage.

This is not insurance provided by Guardian. Instead, your planholder has engaged Guardian only to provide administrative services, such as processing claims. Your planholder's funds will be used to pay these claims. Your planholder is solely responsible and liable for the benefits available under this Plan.

You may not be covered by all of the options in this Member Guide

This Member Guide contains all the benefits and options that are available under this Plan. You are insured only for those benefits and options that you are eligible and enrolled for, and for which the required premium has been paid.

Guardian

The Guardian Life Insurance Company of America
10 Hudson Yards, New York, New York 10001

Dental insurance member guide

Welcome to Guardian!

We've been selected by your organization to provide group dental insurance. We'd like to welcome you to our company!

This is the member guide

This guide explains how this insurance coverage works and gives important details about the coverage.

We're here to help. Contact us if you have any questions or want to talk about any part of this guide.

1-800-627-4200 **guardianlife.com**

Planholder: SANTA CLARA UNIVERSITY

Plan Number: 00056564

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Guide basics

This Member Guide is part of a group insurance Plan

We've entered into an agreement with the Planholder listed on the first page to provide this insurance coverage. The details of the agreement are contained in the Policy we've issued to the Planholder. Check with your Planholder to determine if this coverage is available to you.

This Member Guide is part of the Policy we've issued to the Planholder. Although this is considered a certificate of insurance, we usually refer to this simply as the guide. This guide is important because it tells you how this insurance coverage works.

Unless we specifically say otherwise, when we mention "you" and "your" in this guide, we're referring to you, a member of the organization listed on the first page as the Planholder. Where we say "we" and "us", we're referring to The Guardian Life Insurance Company of America. We usually refer to ourselves simply as Guardian.

How this guide is organized

This guide has five sections. Here's what you'll find in each section:

- **Your benefits**
  This section explains the benefit options that are available to you. This section will help you understand the details of your coverage and how much we'll pay when you receive dental care.

- **Using your benefits**
  This is where you'll find how benefits are paid and how you or your dentist can submit a claim for benefits.

- **Member coverage & family coverage**
  Here's where we explain who's eligible for this coverage and what you need to do to obtain coverage. We also explain what can end your eligibility for coverage.

- **Other things you should know**
  You should review and understand these other items that are also important to your coverage.

- **Covered Services Guide**
  This may be a separate document but is considered part of this guide. It lists the different dental services covered by this guide and explains any limits or requirements you need to know.

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All Options

Your benefits

This section explains the benefits available through this guide, including:

- Dental services that are covered
- How much we'll pay
- Any deductibles and benefit maximums

When we mention family and family members in this section, we're referring to family members who are covered by this guide.

This guide uses the term "benefit year". This is the 12-month period that begins on January 1st and ends on December 31st.

Covered dental services

There are many different dental services you can receive from your dentist. The services for which benefits are available are grouped into one of the categories listed below. These categories will help you understand what we'll pay, as well as any deductibles that must be met.

This list is a summary. For a detailed list of covered services, and the requirements or limits that apply to them, see the Covered Services Guide.

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All Options

What we pay

Preventive services

- In-network dentist 100%
- Out of network dentist 100%

All Options

Basic services

- In-network dentist 100%
- Out of network dentist 80%

All Options

Major services

- In-network dentist 60%
- Out of network dentist 50%

All Options

Orthodontic care

- In-network dentist 50%
- Out of network dentist 50%

All Options

Using a network dentist can save you money

We have a network of dentists to help lower your dental expenses. Our network is called DentalGuard Preferred.

You can go to any dentist you choose, but you can save money by using a dentist in our network. As you can see in the **What we pay** table above, we usually pay a higher percentage of the dentist's fee when you use a dentist in our network.

Also, because dentists in our network will discount their fees for many services, any amount you're responsible for paying may be less if you go to a dentist in our network. This could mean lower out-of-pocket costs for you.

Some states allow dentists in our network to charge the full, undiscounted amount for dental services that aren't covered by this guide. This means if your dentist provides a service that isn't covered by this guide, you won't receive any benefits and you might not receive a discount.

We may pay benefits based on a less expensive alternative treatment or service. We'll do this when the lower cost service would be appropriate based on professionally accepted standards of dental practice.

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All Options

What happens when you use a dentist that isn't in our network

If you use a dentist that isn't in our network, the benefits we pay will be based on the lesser of:

- the dentist's fee
- the amount dentists in your local area typically charge for the same service

Your local area is the area represented by the first 3 digits of the zip code in which your dentist provided the service. The amount dentists typically charge for the same services means that 90% of the dentists charge this amount or less for the service. We determine this amount in accordance with Guardian's Reimbursement Schedule, which includes a combination of insurance market, third party and our own data.

We may pay benefits based on a less expensive alternative treatment or service. We'll do this when the lower cost service would be appropriate based on professionally accepted standards of dental practice. If this happens, we'll use the average cost of the alternative treatment or service in your local area to determine the benefits available.

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All Options

Deductibles

All Options

Annual deductible

- In-network dentist $25.00
- Out of network dentist $25.00

All Options

Must the deductible be met for preventive services?

- In-network dentist . . . . . No
- Out of network dentist . . . . . No

All Options

Must the deductible be met for basic services?

- In-network dentist . . . . . Yes
- Out of network dentist . . . . . Yes

All Options

Must the deductible be met for major services?

- In-network dentist . . . . . Yes
- Out of network dentist . . . . . Yes

All Options

The annual deductible is the amount you're responsible for paying for the dental services you receive during a benefit year before benefits will be available. The annual deductible is listed in the table above.

The annual deductible must be met by you and each of your family members separately. Benefits will be available to you once you've met this deductible. Benefits will be available to a family member when that family member has met this deductible.

When a total of 3 people in your family have each met the annual deductible, we'll consider everyone in the family to have met it.

Benefits for some dental services are available without any deductible having to be met. This is also listed in the table above.

Only dental expenses that are otherwise covered and that would be paid by this guide can be used to meet your deductible. In other words, only the amount in benefits that would be paid if there was no deductible will be applied to the deductible. You won't be reimbursed for any expenses that are applied to the deductible.

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All Options

In-network vs. out of network
Any fees applied to the deductible when you use a DentalGuard Preferred dentist will also be applied to the deductible for services you receive from a dentist that isn't in our network. Similarly, any fees applied to the deductible when you use a dentist that isn't in our network will also be applied to the deductible for services you receive from a DentalGuard Preferred dentist.

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All Options

Deductible(s) satisfied under a prior plan
If this Plan replaced a prior plan, we'll give you credit for any portion of the annual deductible that had already been met for the same benefit year. Documentation of the expenses applied to the prior plan's deductible will be required.

A prior plan is the plan that your Planholder had immediately before this Plan. For it to be considered a prior plan, it must have ended the day before this Plan began.

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All Options

Benefit maximums

A benefit maximum is the most we'll pay for dental services received during a specific period of time, such as a benefit year or during your lifetime on this Plan. Once we've paid this amount, no additional benefits will be available for services received during that period.

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All Options

Annual maximum

- In-network dentist $3,500.00
- Out of network dentist $3,500.00

All Options

Orthodontic lifetime maximum

- In-network dentist $3,000.00
- Out of network dentist $3,000.00

All Options

The annual maximum is the most we'll pay in benefits for dental services you receive during a benefit year. The annual maximum is listed in the table above.

This maximum applies to you and each of your family members separately. This means you each have an annual maximum in the amount listed in the table above.

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All Options

Orthodontic care lifetime maximum

Orthodontic care has its own lifetime maximum. This is the most we'll pay in benefits for orthodontic care received during your lifetime on this Plan. The orthodontic care lifetime maximum is listed in the table above.

This maximum applies to each person that receives orthodontic care benefits separately. This means each person eligible to receive orthodontic care benefits has a lifetime maximum in the amount listed in the table above.

Benefits paid for orthodontic care will count toward the orthodontic care lifetime maximum, but not the annual maximum for other services listed above.

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All Options

In-network vs. out of network
The maximum benefits available may depend on the type of dentist you use. This is listed in the above table.

Benefits paid for services received from a DentalGuard Preferred dentist will also count toward the maximum amount available for services received from a dentist that isn't in our network. Similarly, any benefits paid for services received from a dentist that isn't in our network will also count toward the maximum amount available for services you receive from a DentalGuard Preferred dentist.

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All Options

Benefits paid under a prior plan
If this Plan replaced a prior plan, any benefits paid for dental services received during the same benefit year will be deducted from the annual maximum listed above. Documentation of benefits paid under the prior plan will be required.

Any benefits paid under a prior plan for orthodontic care will be deducted from this Plan's orthodontic care lifetime maximum.

A prior plan is the plan that your Planholder had immediately before this Plan. For it to be considered a prior plan, it must have ended the day before this Plan began.

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All Options

Benefit maximum rollover

A portion of benefits that you don't use in one benefit year can be carried over for future use. If you reach the annual maximum in a benefit year, you can use any benefits that were previously rolled over to help pay for your dental care.

We'll roll over a portion of unused benefits at the beginning of a new benefit year if:

- We paid benefits for dental services you received during the previous benefit year.
- The benefits we paid for dental services you received during the previous benefit year didn't exceed the rollover threshold of $1,000.00.
- You were eligible to receive benefits for major services during the previous benefit year.
- You had the benefit maximum rollover in place with this Plan before 10/01 of the previous benefit year.

The amount that will be rolled over each benefit year is $500.00.

The maximum amount you can have rolled over at any one time is $1,500.00.

Bonus rollover reward
We'll add a bonus rollover reward of $750.00 if you used an in-network dentist for all the dental services you received during the benefit year.

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All Options

Using the rollover
If you reach your annual maximum during a benefit year, we'll use the rollover amount to continue to pay benefits for dental services received during the same benefit year. When all the rolled over benefits have been used, no additional benefits will be available for dental services you receive in that benefit year.

The rollover benefits can't be used to pay for orthodontic care.

Any rolled over benefits will be lost if your coverage under this Plan ends, or if there's any break in coverage.

The rollover benefit applies to you and each of your family members separately. This means the benefits paid and the amounts rolled over are calculated for each person separately.

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All Options

Waiting period if you enroll late
If you don't enroll for coverage within the time allowed benefits for some dental services won't be available until after you've met a waiting period. You won't receive any benefits for the following dental services if they're received during the waiting period listed:

Dental service

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All Options

- Basic services . . . . . 6 months
- Major services . . . . . 12 months
- Orthodontic services . . . . . 24 months

The same waiting periods must be satisfied by each family member that's enrolled late.

The waiting periods listed above are in addition to any other waiting periods included under this Plan. This means the waiting periods for enrolling late will not begin until any other waiting period for the same dental service has been satisfied.

Dental services received within the waiting period won't be covered and can't be used to meet the deductible.

See the **You must enroll within the time allowed** section for more information.

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Using your benefits

Timely access to care

California law requires dental plans to provide timely access to care. This means that there are limits on how long you have to wait to get dental appointments and telephone advice.

- Urgent appointments - You have the right to an appointment within 72 hours.
- Non-urgent appointments - You have the right to:
  - A non-urgent appointment within 36 business days
  - Preventive care appointments within 40 business days

The wait time standards don't apply if you're requesting a specific date and time.

Continuity of care

If your dentist leaves our network while you're receiving covered services for an acute condition, we'll consider the completion of those services for that condition as being performed by an in network dentist.

At your request, we can arrange for the completion of covered services by the terminated dentist for the remainder of the acute condition. An acute condition means a dental condition that involves a sudden onset of symptoms that requires prompt attention and that has a limited duration. A terminated dentist means a dentist whose contract to provide services is terminated or not renewed by us or one our contracting dental groups. You must be undergoing a course of treatment for an acute condition and your coverage under the policy must continue during the completion of covered services.

Paying your dentist

When you receive dental care, your dentist might submit your claim and wait to see what we pay before asking you to pay anything. Or your dentist could ask that you pay for the services at the time you receive them. Then, either you or your dentist can submit your claim for benefits under this Plan.

See the **What you should do when you have a claim** section for more information on how to send us your claim.

What you're responsible for paying

You're responsible for paying your dentist for any dental expenses that aren't covered by this guide. This includes any deductibles and any other amounts we don't pay. For example, if we pay 80% of a covered service, this means you must pay the other 20%. This is sometimes referred to as "coinsurance".

You're also responsible for paying any fees for services that exceed what's allowed by this guide.

If you use an in-network dentist, you don't need to pay any amounts that are over the discounted amount your dentist agreed to accept. See the **Using a network dentist can save you money** section for more information.

Pre-treatment review of proposed dental services

If you'd like to know how much we'll pay for a dental service before you receive it, we encourage you to have your dentist submit a pre-treatment review. We'll compare the services proposed to the benefits available under this guide and tell you how much we expect to pay. You'll then know how much of the dentist's fee you'll have to pay.

Although these reviews are completely optional, they're a good way to avoid surprises.

Please keep in mind, the amount we tell you we expect to pay is an estimate. The amount we'll pay when you receive the service can change because of factors such as the maximum benefits remaining, your dentist's participation in our network and you continuing to be covered under this Plan.

Your dentist can submit a pre-treatment review in the same way that a claim is submitted. If you have any questions on how to do this, contact your dentist or visit us at guardianlife.com.

Once you've received the proposed services, a claim will need to be submitted so we can pay any benefits available. See the **What you should do when you have a claim** section for more information.

What you should do when you have a claim

Your dentist might submit your claim for you. If your dentist doesn't submit your claim, you can do it yourself by following these simple steps:

Step 1 - Start your claim

When you have a claim, you'll need to complete a claim form. Part of the form will have to be filled out by your dentist. When it's complete, you or your dentist should send it to us.

You can print a claim form by going to guardianlife.com.

You can also call us at 800-541-7846 to request a claim form.

You can also write to us to tell us you have a claim. Our address for claims is:

Guardian
Group Dental Claims Department
P.O. Box 981572
El Paso, TX 79998-1572

If we don't send you a claim form within 15 days of when you asked for it, you can still submit your claim. To do so, mail us a copy of the dentist's bill. This should identify who you are and include the date(s) and details about the services received. Send this to the address listed above.

Step 2 - Submit your claim

If you're submitting a paper claim, the completed claim form should be mailed to:

Guardian
Group Dental Claims Department
P.O. Box 981572
El Paso, TX 79998-1572

Be sure to include all the information and copies of any documents the instructions indicate are necessary. The claim form and supporting documents are referred to as "proof of loss".

You or your dentist should submit your proof of loss as soon as you can, but you must submit it within 15 months of the date you received the dental services for which you're seeking benefits.

We'll only consider claims submitted after this 15 month period if you were legally incapacitated and unable to submit it within the time allowed.

What we'll do when we receive your claim

We'll review your claim to make sure it's complete

- We'll conduct a full and fair review of your claim.
- We'll complete our review of your claim within 30 days of receiving your proof of loss.

- In the event we need more time to consider your claim, which might be the case if we need more information, we can extend this review period by an additional 60 days. We'll notify you in writing if this happens and we'll explain the reason(s) more time is needed.
- If we need more information to consider your claim, we may request this information directly from your dentist. We may need to obtain X-rays, periodontal charting, narratives and other diagnostic information to consider your claim. Your dentist must provide us with the information we need to evaluate your treatment and determine the benefits payable.
- We may use the professional review of a dentist to determine the appropriate benefit for a dental service or course of treatment.
- If we need additional information from you, we'll let you know.

We'll determine if benefits are payable

- We'll make a decision within 30 days of our receiving the information needed to consider your claim.
- If benefits are payable, we'll pay the amount specified in this guide.
- If we deny any part of your claim, we'll provide a written explanation of the specific reason(s) your claim wasn't paid. We'll also include information on how you can appeal our decision.

When we'll pay

If we determine benefits are payable, they'll be paid promptly, and no more than 30 days from the date we receive the information needed to make the decision on your claim.

Who we'll pay

If an in-network dentist provided your dental services, we'll pay the benefits directly to your dentist.

If a dentist that isn't in our network provided your dental services, we'll pay the benefits to you unless you instruct us to pay your dentist directly.

If you're no longer living, we have the right to pay your benefits to one of the following, in the order listed:

- Your spouse
- Your children
- Your parents
- Your estate

If benefits are payable to your estate, and the amount is $1,000 or less, we can pay someone related to you by blood or marriage who we believe is entitled to the benefits. Any such payment will meet our obligations under this Plan.

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All Options

What happens if your claim is denied

If we deny your claim or a part of your claim, we'll provide a written explanation within 30 days of our receiving the information we needed to make the decision. This explanation will include the specific reasons the claim was denied.

If we deny your claim because you or your dentist didn't reply to our requests for information, we'll provide a written explanation within 30 days of the date the information was due. This explanation will list the information you or your dentist were asked to submit.

We'll also provide instructions listing your rights to appeal your claim. These will explain the following:

- You'll need to submit a written appeal within 180 days of receiving our claims decision. The appeal should include any additional information or documentation you or your dentist think would be important for us to consider. Send your appeal to the address listed in the appeal instructions.
- We'll conduct a full and fair review of your appeal.
- We'll complete our review within 60 days of our receipt of your appeal.

- In the event we need more time to consider your appeal, which might happen if we need additional information, we can extend this review period by another 60 days. We'll let you know if additional time or information is needed.
- We'll let you know of our decision in writing. If we deny your appeal, we'll provide the specific reasons for the denial.

You should refer to the instructions included with any denial for more information on the appeals process.

What you can do if you have a complaint or grievance
If you have a complaint or grievance, you can call us at 800-541-7846 and we'll provide you with instructions on how to file your complaint or grievance.

You can also contact the California Department of Insurance:

Department of Insurance
300 South Spring Street
Los Angeles, California 90013
Consumer Hotline: 1-800-927-HELP (4357)
TDD: 1-800-482-4TDD (4883)

Website: www.insurance.ca.gov/01-consumers/

Other things you should know about claims

Who pays first when you're covered by more than one plan
Because you and any family members covered by this Plan may have other dental coverage, we need to determine which plan is responsible for paying first. We coordinate benefits with other plans, so the total amount of benefits paid doesn't exceed the allowable amount for the services received.

This Plan will pay any benefits available for the covered services you receive before any other dental plan.

For covered services your spouse receives, the plan that will pay any benefits available first will be:
- Your spouse's plan if your spouse is covered as an active employee.
- The plan that's been in place the longest if the above rule doesn't apply.

For covered services your child receives, the plan that will pay any benefits available first will be:
- The plan of the parent whose birthday is earlier in the year.
- For a child whose parents are separated and not living together:
  - In an equal custody split, the plan of the parent whose birthday is earlier in the year.
  - The plan identified by any applicable court order.
  - If there isn't a court order that says which plan pays first, the dental services will be paid in the following order:
    - The plan of a biological parent with custody pays first.
    - The plan of a stepparent with custody pays second.
    - The plan of a biological parent without custody pays third.
    - The plan of a stepparent without custody pays fourth.

Coordinating benefits
When this Plan pays benefits first, we'll calculate the benefits payable as if you have no other dental coverage.

When another plan pays benefits first, the benefits available under this Plan will be calculated so that the total amount of benefits paid between all of your plans combined doesn't exceed the allowable amount for the services received. We also won't pay more in benefits than we'd pay if this Plan paid first.

A dentist that's in a network has agreed to charge a certain amount for specific dental services. These amounts are listed in what we call a fee schedule. We apply the following rules when determining the benefits available:

- When both plans use a fee schedule, the schedule allowing the higher fee will be used.
- When the plan that pays first is the only plan that uses a fee schedule, that plan's fee schedule will be used.
- When another plan pays first and doesn't use a fee schedule, the fee schedule for this Plan will be used.
- When neither plan uses a fee schedule, the highest allowable amount offered by either plan will be used.

Overpayments
If we paid more in benefits than this guide offers, you'll have to return the amount of the overpayment to us. We may ask you to send us the overpayment, or we might deduct the overpayment from future benefits.

Legal action
You can't bring a legal action under this Plan until 60 days after you've submitted proof of loss. You also can't bring a legal action more than three years from the time proof of loss is required, or the date we make a decision on your claim, whichever is later.

Examination
While we're reviewing your claim or appeal, we may require that you be examined by a medical or dental practitioner of our choice as often as reasonably necessary.

We'll pay for any examination we require.

Insurance fraud
We can terminate this coverage if you or your representative commits fraud with respect to a claim.

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All Options

Member coverage

Who's eligible

To be eligible for coverage under the Plan, you must meet the following requirements:

You must be in an eligible class of members
Your Planholder may choose to offer coverage to all members or only to those in certain job classifications.

A job classification or class of members is a group of members that fit into the same category. For example, a Planholder could have one class for hourly employees and another class for salaried employees.

If only certain classes are eligible for coverage, you must be in one of these classes to obtain coverage. If you have any questions about your eligibility, please contact your Planholder.

You must meet the minimum number of working hours required
You need to be actively working and performing the regular duties of your job. You must be working the number of hours your Planholder requires for your class, and not less than 20 hours per week.

Eligible retirees don't need to meet this requirement.

You must wait to be eligible for coverage
Your Planholder has a waiting period that new members must meet before they can be eligible for this coverage. Your Planholder can tell you if you must meet a waiting period and how long it lasts.

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All Options

How to get coverage

If you meet the eligibility rules listed above, you must also do the following to obtain coverage:

You must enroll within the time allowed
You must enroll within 31 days of the date you first become eligible for coverage.

You can also enroll when you have a qualifying life event
If you don't enroll within the time allowed, you can enroll within 31 days of a qualifying life event. This includes:

- Your coverage ending under another dental plan
- Your legal separation or divorce or dissolution of a civil union or domestic partnership
- Your loss of coverage under your spouse's dental plan
- An event required by state or federal law or specified by your Planholder's guidelines

What happens if you enroll late

If you don't enroll within the time allowed, you'll be able to enroll during the next open enrollment period.

Enrollment periods usually occur once every year. We agree with your Planholder on when open enrollment periods happen, and how long they last.

If you have any questions about the open enrollment periods or when you can enroll, please contact your Planholder.

You may have to satisfy a waiting period if you enroll late. See the **Waiting period if you enroll late** section for more information.

Your premium must be paid
We must receive the required premium for your coverage.

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All Options

When your coverage begins

If you're eligible for coverage and have done what's required to obtain coverage, as explained under **How to get coverage,** your coverage begins at 12:01 AM EST on the first day you became eligible for coverage.

You must be actively at work, performing the major duties of your regular job and working the required number of hours at the location required by your Planholder on the date your coverage is scheduled to begin. If you don't meet this requirement, your coverage won't begin until you return to being actively at work, performing the major duties of your regular job and working the required number of hours at the location required by your Planholder.

Your coverage may be scheduled to begin on or during one of the following:

- A holiday
- A vacation day
- A day you're not scheduled to work

If this happens, coverage will still begin on that same day if you were actively at work, performing the major duties of your regular job and working the required number of hours at the location required by your Planholder on your last regularly scheduled workday.

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All Options

When your coverage ends

Your coverage will end at 11:59 PM EST on the earliest of the following:

- The last day of the month in which you're no longer eligible under this guide.
- The date this coverage is no longer available to the class of members to which you belong.
- The last day of the period or which the required premiums have been paid.
- The day you die.
- The day this Plan ends.

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All Options

COBRA continuation rights
If your coverage ends, or a family member's coverage ends, you may be able to keep this coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, (COBRA). If you have any questions, please contact your Planholder or visit us at guardianlife.com.

Keeping your coverage when you aren't working
If you temporarily stop working, there may be a limited time during which you can keep your coverage.
Premiums must continue to be paid during this time. Please contact your Planholder if you have any questions.

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All Options

Family leave of absence - Family & Medical Leave Act (FMLA) & Uniformed Services Employment & Re-employment Rights Act (USERRA)
These options are available only if your Planholder is legally required to allow for a family leave of absence. You can confirm with your Planholder if these options are available.

If these options are available to you, you can keep this coverage when you take a leave of absence approved by your Planholder for one of the following reasons:

- To care for a seriously injured or ill spouse, child, or parent
- Within 12 months following the birth or adoption of a child
- Due to your own serious health condition
- To care for a spouse, child, parent or next of kin, who's your closest blood relative, that suffered a sickness or injury while on active duty in the US Armed Forces

You can keep this coverage while on leave for up to 12 weeks in any 12-month period. However, if the leave is to care for a family member who was injured or became ill while on active duty, as explained above, you'll be able to keep this coverage for up to 26 weeks of leave in a 12-month period.

If you take a family leave for any other reason during this same 12-month period, this will count toward the 26-week maximum.

Any subsequent leave to care for a service member will be limited to 12 weeks.

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All Options

Family coverage

Who's eligible

The following family members are eligible for coverage:

- Your spouse, civil union partner or domestic partner

  A spouse is the person to whom you're legally married, your civil union partner, or your domestic partner.

  Your domestic partner is the person of the same or different sex with whom you live and share financial assets and obligations. Your domestic partner must be able to provide legal consent and can't be a blood relative. You and your domestic partner may not be married to, in a domestic partnership with, or legally separated from anyone else.

  Your domestic partnership must be registered with a state or local government registry.

  We won't require proof of registered domestic partnership that we wouldn't require of a marriage.

B650.0487

All Options

- Your child, who's
  - Under the age of 26

  Your child is one of the following:
  - Your biological child
  - Your stepchild
  - A child placed with you for adoption or foster care
  - A child for whom you've been appointed a legal guardian and who you claim as a dependent on your federal income taxes

  A child who's incapable of self-support because of mental, physical, or developmental disability may be able to keep this coverage past the maximum age. See the **Keeping this coverage for a child who reaches the age limit** section.

B650.0491

All Options

Family members that aren't eligible

- A family member who's on active duty in the armed forces.
- A child who's an eligible dependent of more than one member can be covered through only one member.
- A family member who's also eligible for coverage as a member under this Plan can't be covered more than once.

B650.1199

All Options

How to get coverage for your family

If your family member(s) are eligible, you must do the following to obtain coverage:

You must be enrolled
In order to enroll your family members, you must already be enrolled for coverage, or you must enroll yourself when you enroll them.

You must enroll your family members
You can enroll your eligible family members when they first become eligible.

You can enroll family members when there's a qualifying life event
You can also enroll an eligible family member within 31 days of a qualifying event. This includes:

- Your marriage or entrance into a domestic partnership
- Your legal separation or divorce or dissolution of a civil union or domestic partnership
- The death of your spouse
- The birth or adoption of your child or your assuming legal responsibility for a foster child
- Your spouse's loss of coverage under another dental plan
- Your spouse's loss of employment

Your biological children are automatically covered for the first 31 days following their birth. Your adopted children and foster children are automatically covered for the first 31 days from the date they are placed in your care.

You must enroll biological, adopted, and foster children and pay the required premium within this 31-day period or their coverage will end when the 31 days are over.

What happens if you enroll family members late
If you didn't enroll your eligible family members within the time allowed, you'll be able to enroll them during the next open enrollment period.

They may have to satisfy a waiting period because you enrolled them late. See the **Waiting period if you enroll late** section for more information.

The premium must be paid
We must receive the required premium for family coverage.

B650.0496

All Options

When family coverage begins

If you enrolled your family members when you enrolled yourself, their coverage begins at the same time your coverage begins. If you did not enroll your family members at the same time you enrolled yourself, their coverage will begin at 12:01 AM EST on the date you enroll them.

B650.0499

All Options

When family coverage ends

Coverage for your family member will end at 11:59 PM EST on the earliest of the following:

- The date your coverage ends.
- The date you stop being a member of a class that's eligible for family member coverage.
- The last day of the period for which the required premiums were paid.

- For a spouse, the last day of the month in which your marriage ends in divorce or annulment or your civil union or domestic partnership is dissolved.
- For a child, the last day of the month in which your child reaches the maximum age or no longer meets the conditions listed under **Keeping this coverage for a child who reaches the age limit.**
- The date the family member becomes ineligible for any of the reasons listed in the **Family members that aren't eligible** section.
- The date the family member dies.

If your coverage ends because of your death, your family members may continue their coverage in accordance with the **Family survivorship benefit.** See the **Family survivorship benefit** for more information.

B650.0508

All Options

Keeping this coverage for a child who reaches the age limit
A child may keep this coverage past the age limit if the child is all the following:

- Unable to live independently due to a mental, physical, or developmental disability, injury, illness, or condition which began before reaching the maximum age
- Primarily dependent upon you for financial support
- Continuously covered by this Plan, or by the group plan this Plan replaced, through the time the maximum age was reached

You'll have to send us proof that your child meets these requirements within 60 days of the date the maximum age was reached.

After two years have passed from the date the maximum age was reached, we may periodically ask for documentation that your child continues to meet these requirements. We won't ask for this more than once a year.

Coverage extended in accordance with this section will end when your child no longer meets the conditions above. Even when your child does meet the requirements listed above, this coverage can end due to any of the reasons, other than reaching the maximum age, listed under the **When family coverage ends** section.

B650.1135

All Options

Family survivorship benefit

If you die while you're covered by this Plan, we'll continue to provide coverage to any family members that were covered by this guide at the time of your death. This continued coverage will be provided at no cost to them.

We'll continue to cover your family members for 6 months after the date of your death. Coverage will end on the date this 6-month period ends.

This coverage will end sooner:

- For any family member whose coverage ends for other reasons - see the **Family coverage** section for more information
- For your spouse, upon remarriage
- If this Plan ends

Coverage will end on the date any of above occur.

If a family member elects to keep coverage under COBRA, the family survivorship benefit will be provided during the first 6 months of the continuation. See **COBRA continuation rights** for more information.

B650.0501

Other things you should know

Paying the premiums

For your insurance coverage to be in place, the required premiums must be paid. We worked with your Planholder to decide how and when the premium payments must be made.

The premiums can be changed at any time. We'll give your Planholder 31 days advance notice of any change in premiums.

If you have any questions about premium payments, please contact the Planholder.

Be sure to give us complete and accurate information

If we asked you to provide personal, health or medical information about yourself or your family members at the time of enrollment, it's important that the information you provided was complete and accurate. If it wasn't, we have the right to challenge a claim for benefits. This means we can deny a claim that might otherwise be covered.

If you don't give us complete and accurate information, we may also have the right to rescind this coverage. This means we would declare your guide to be null and void as of its effective date. In that case, we'd refund all the premiums paid and it would be as though your insurance coverage had never been issued.

During the first two years this guide is effective, we can rescind it if any material information you provided in or with an enrollment form or application was missing or inaccurate. Information is considered material if it would have caused us to:

- Not issue any coverage
- Issue your guide with different coverage or benefit amounts
- Issue your guide with different premium amounts

After this guide has been in place for more than two years, we can only rescind it if you committed fraud.

We won't challenge a claim or contest whether this coverage is valid unless the statement in question was made in writing and signed by you.

All statements made in your application will be considered representations, not warranties. This means you're asserting that the information you have listed on your application is accurate. You're not, however, promising to do anything for us if this assertion turns out to be false.

Any increase in benefits will be subject to these same requirements, with the two years described above beginning on the effective date of the increase.

Review the information you provided at the time of enrollment or application to make sure it's complete and accurate. If you find anything is missing or inaccurate, you must immediately notify us in writing at the address listed on the first page of this guide.

Misstatement of age

If your age or a family member's age is found to be incorrect, we may need to make an adjustment in the coverage and the premiums.

If the true age would have prevented us from issuing any coverage, this coverage will be terminated from the beginning and a refund of premiums will be made. Any benefits previously paid will be deducted from the refund.

Advance notice of change

We'll provide written notification at least 60 days prior to any of the following:

- Plan termination
- Premium increases
- Benefit reduction or elimination
- Eligibility restrictions

B650.1136

Guardian®

The Guardian Life Insurance Company of America
10 Hudson Yards, New York, New York 10001

Covered services guide

This is the covered services guide

This guide explains the dental services that are covered and how much we'll pay.

We're here to help. Contact us if you have any questions or want to talk about any part of this guide.

1-800-541-7846 **guardianlife.com**

Planholder: SANTA CLARA UNIVERSITY

Plan Number: 00056564

IMPORTANT: If you opt to receive dental services that are not covered services under this policy, a network dentist may charge you their usual and customary rate for those services. Prior to providing you with dental services that are not a covered benefit, the dentist should provide to you a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call us at 1-888-GUARDIAN. To fully understand your coverage, you may wish to carefully review this document.

B651.1241

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All Options

Guide basics

Covered dental services

For a dental service to be considered for benefits:

- The service must be provided while you're covered by this Plan. If the service is for a family member, it must be provided while the family member is covered by this Plan. Unless we say otherwise in this guide, the date the dental service is performed will be the date we use to determine the benefits available.
- The service must be provided by a dental or medical practitioner who's properly licensed or certified by the state where the services are provided, and who provides dental services within the scope of this license or certification.
- The service must be provided within the professionally accepted standards of dental practices and be necessary and appropriate for your dental condition.
- The service must be covered by this guide.

There are many different dental services you can receive. This Covered Services Guide lists the most common services, but there can be other dental services not listed here that may also be covered. You or your dentist can contact us with any questions about any dental service you don't see in this guide.

Your dentist will give us a CDT (Current Dental Terminology) code to tell us which service you received. These CDT codes are approved by the American Dental Association and are used by all dentists.

Because dental terminology is updated from time to time, the most current dental terminology may not be reflected in this guide. We'll use the most current dental terminology when we receive your claim and determine the benefits payable.

Some dental services involve more than one procedure. Each procedure will be considered part of the overall service when we determine the benefits payable.

You and your dentist have the right and responsibility to decide upon the best course of treatment for you based on your dental needs, regardless of what benefits may be available. If more than one dental service can be used to treat your dental condition, we'll use the least costly option when we determine the benefits payable.

What we pay

In the Member Guide, we told you about deductibles and benefit maximums. In this guide, we'll give you the details on how much of the dentist's fees we'll pay.

How often

This is where we tell you how often you can have the service and receive the benefits available for that service.

Other things you should know

Here, we'll give you a brief description of each service and tell you other things you need to know about the benefits available.

B651.0006

Office Visits, X-rays & Cleanings - Diagnostic & Preventive Care

Office visits & evaluations

This section explains the benefits available when you go to the dentist for an office visit or evaluation.

Office visits, oral evaluations & comprehensive evaluations . . . . . **Preventive**

What we pay:
- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:
- 3 time(s) every calendar year
- 1 time every 36 months for comprehensive evaluations per dentist

Other things you should know:
- These include any regular check-ups and dental evaluations.
- Office visits and evaluations count toward the same maximum number allowed.

Emergency problem-focused evaluations . . . . . **Preventive**

What we pay:
- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:
- 2 time(s) every calendar year

Other things you should know:
- This type of evaluation may be needed when there is a specific dental problem that needs attention right away.

After-hours office visits & palliative treatment visits . . . . . **Basic**

What we pay:
- When you use an in-network dentist **100%**
- When you use an out of network dentist **80%**

How often:
- As needed

Other things you should know:
- After-hours visits take place outside normal office hours.
- Palliative treatment is provided to relieve pain or discomfort.

X-rays - radiographic images

This section explains the benefits available for the various types of X-rays or images your dentist may take during your dental visit. Your dentist may refer to X-rays as radiographic images.

Complete series & panoramic X-rays . . . . . **Preventive**

What we pay:
- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:
- 1 time(s) every 60 months

Other things you should know:
- A complete series captures an image of every tooth.
- A panoramic X-ray shows all the teeth, surrounding bone and other structures in the mouth.

Bitewing X-rays . . . . . **Preventive**

What we pay:
- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:
- 2 times every calendar year if the X-rays are taken on those under the age of 18 and 1 time every calendar year for people over this age.

Other things you should know:
- These X-rays show gum disease and cavities between the teeth.
- This benefit is available for a total of 4 bitewing images, or vertical bitewing images in 1 visit.

Intraoral periapical & occlusal X-rays . . . . . **Preventive**

What we pay:
- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:
- As needed

Other things you should know:
- A periapical X-ray is a single X-ray that shows the whole tooth, including the roots.
- An occlusal X-ray is a single X-ray that shows the roof or floor of the mouth.

Dental cleanings, preventive care & other diagnostic services

This section explains the benefits available for cleanings and other types of preventive care aimed at keeping your teeth and gums healthy.

Dental cleanings . . . . . **Preventive**

What we pay:
- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:
- 4 time(s) every calendar year
- 1 time every 12 months for a medically necessary cleaning

Other things you should know:
- This removes plaque, tartar, and stains from the teeth. It can be performed by a dentist or dental hygienist. Your dentist may call this a prophylaxis.
- Periodontal maintenance visits will count toward the number of dental cleanings allowed. Dental cleanings will also count toward the number of periodontal maintenance visits allowed.
- This benefit for an additional cleaning is available if the cleaning is needed because of health conditions.
- We may ask that your physician provide a written explanation of why an additional cleaning is needed.

Fluoride . . . . . **Preventive**

What we pay:
- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:
- 2 time(s) every calendar year

Other things you should know:
- This helps prevent cavities by strengthening the outer surface of the teeth. Fluoride can be applied to the teeth as a mouth rinse, gel, or foam.

Sealants . . . . . **Basic**

What we pay:
- When you use an in-network dentist **100%**
- When you use an out of network dentist **80%**

How often:
- 1 time(s) per tooth every 24 months

Other things you should know:
- These are thin, protective resin coatings that adhere to the chewing surface of the back teeth to help prevent cavities.
- This benefit is only available for those under the age of 16.
- This benefit is only available for adult (permanent) molar teeth.

Space maintainer . . . . . **Preventive**

What we pay:
- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:
- As needed

Other things you should know:
- This appliance helps preserve space for adult (permanent) teeth when 1 or more baby (primary) teeth are lost too early.
- All services associated with the space maintainer, including adjustments made within 6 months and re-cementations made within 12 months of the space maintainer being inserted, will be considered part of the space maintainer.

Harmful habit appliance . . . . . **Preventive**

What we pay:
- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:
- 1 appliance during the lifetime of this plan

Other things you should know:
- This appliance is temporarily cemented to certain teeth to prevent a child from sucking a thumb, finger, or pacifier.
- This benefit is available only for those under the age of 14.

Dental model . . . . . **Preventive**

What we pay:
- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:
- 1 model

Other things you should know:
- These are replicas of the upper or lower teeth and are made of stone or plaster. Your dentist may call this a diagnostic cast.
- This benefit is only available when 3 or more of the following are needed at the same time for both the upper and lower teeth:
  - Dentures
  - Crowns
  - Bridges
  - Onlays
  - Full mouth adjustment of the bite

Fillings, Crowns & Other Repairs - Tooth Restorations

Fillings

This section explains the benefits available for dental fillings.

Fillings . . . . . **Basic**

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **80%**

How often:

- As needed

Other things you should know:

- These are used to restore a tooth damaged by decay or when part of a tooth has broken off. Your dentist may call a silver-colored filling an amalgam restoration. Your dentist may call a tooth-colored filling a resin or composite restoration.
- All services associated with a filling, such as bonding agents, liners, bases, polishing, bite adjustments, and local anesthetic, will be considered part of the filling.

Crowns

This section explains the benefits available when you have a crown placed on a tooth.

Crowns . . . . . **Major**

What we pay:

- When you use an in-network dentist **60%**
- When you use an out of network dentist **50%**

How often:

- 1 time per tooth every 5 years
- For a replacement, the crown must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:

- When a tooth has been damaged by decay or part of a tooth has broken and it can't be repaired with a filling, the tooth may be restored to normal function with a crown. This is sometimes called a cap.
- A crown can be made of metal, porcelain (a tooth-colored material), or both, where porcelain covers the metal underneath.
- This benefit is available only when the crown is needed because of decay or missing tooth structure and the tooth can't be restored with a filling.
- This benefit is available for adult (permanent) teeth only.
- The benefit for a noble metal crown is available for all teeth. If a more expensive material is used, what we pay will be based on the cost of a noble metal crown.
- A crown that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and it can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.
- All services associated with a crown, such as insulating bases, temporary or provisional restorations, local anesthetic or associated gingival involvement, will be considered part of the crown.
- The day the tooth is prepared for the crown will be considered the date the service is performed.

Prefabricated crowns . . . . . **Basic**

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **80%**

How often:

- 1 time per tooth every 24 months

Other things you should know:

- When a tooth has been damaged by decay or part of a tooth has broken and it can't be repaired with a filling, the tooth may be restored to normal function with a prefabricated crown. Prefabricated crowns are usually used on baby (primary) teeth.
- A crown can be made of stainless steel, porcelain (a tooth-colored material), resin (also a tooth-colored material) or a combination, where porcelain covers the metal underneath.
- When a prefabricated crown is replaced within 24 months by a permanent crown, the prefabricated crown will be considered temporary and part of the permanent restoration.

Other tooth restoration services

This section explains the benefits available for other types of restorations or repairs your teeth may need.

Onlays & labial veneers . . . . . **Major**

What we pay:
- When you use an in-network dentist **60%**
- When you use an out of network dentist **50%**

How often:
- 1 time per tooth every 5 years
- For a replacement, the restoration must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:
- These are used when a filling can't be used to restore a tooth damaged by decay or replace a part of the tooth that has broken off.
- Onlays are like crowns, but instead of covering the entire tooth, they cover only the damaged part of the tooth.
- A veneer is a tooth-colored material that's placed on the front of the tooth. These are used on anterior teeth only. These are the incisor and cuspid teeth located in the front of the mouth.
- This benefit is available only when the restoration is needed because of decay or missing tooth structure and the tooth can't be restored with a filling.
- This benefit is available for adult (permanent) teeth only.
- The benefit for a noble metal onlay is available for all teeth. If a more expensive material is used, what we pay will be based on the cost of a noble metal onlay.
- An onlay or veneer that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.
- All services associated with the restoration, such as insulating bases, temporary or provisional restorations, local anesthetic or associated gingival involvement, will be considered part of the restoration.
- The day the tooth is prepared for the restoration will be considered the date the service is performed.

Core buildup & post & core . . . . . **Major**

What we pay:
- When you use an in-network dentist **60%**
- When you use an out of network dentist **50%**

How often:
- 1 time per tooth every 5 years
- For a replacement, the restoration must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:
- A core buildup and a post and core are done to strengthen a tooth that has been broken or damaged by decay so a crown can be placed.
- This benefit is available only when this service is done with a covered crown or bridge retainer and when needed because of substantial loss of tooth structure.
- This benefit is available for adult (permanent) teeth only.

Crown & restoration repairs . . . . . **Major**

What we pay:
- When you use an in-network dentist **60%**
- When you use an out of network dentist **50%**

How often:
- As needed

Other things you should know:
- Sometimes a crown, onlay or veneer can be repaired instead of replaced.

Re-cement & re-bond . . . . . **Major**

What we pay:
- When you use an in-network dentist **60%**
- When you use an out of network dentist **50%**

How often:
- As needed

Other things you should know:
- Sometimes a crown, onlay or veneer may need to be re-cemented or re-bonded.

Root Canals & Related Services - Endodontic Care

Root canals

This section explains the benefits available when you have a root canal performed.

Root canal - anterior & bicuspid teeth . . . . . **Basic**

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **80%**

How often:

- 1 time per tooth
- If a tooth needs to be retreated, this benefit is available 1 time per tooth.

Other things you should know:

- This is done to remove the nerve inside the tooth. A filling is placed where the nerve used to be. Your dentist may call this endodontic therapy.
- This benefit is available for adult (permanent) teeth only.
- All services associated with a root canal, such as X-ray images, cultures and tests, local anesthetic, the protective restoration, and routine follow up care, will be considered part of the root canal.
- The day the tooth is initially opened for a root canal will be considered the date the service is performed.

Root canal - molar teeth . . . . . **Basic**

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **80%**

How often:

- 1 time per tooth
- If a tooth needs to be retreated, this benefit is available 1 time per tooth.

Other things you should know:

- This is done to remove the nerve inside the tooth. A filling is placed where the nerve used to be. Your dentist may call this endodontic therapy.
- This benefit is available for adult (permanent) teeth only.
- All services associated with a root canal, such as X-ray images, cultures and tests, local anesthetic, the protective restoration, and routine follow up care, will be considered part of the root canal.
- The day the tooth is initially opened for a root canal will be considered the date the service is performed.

Other endodontic services

This section explains the benefits available for other endodontic procedures.

Pulp cap . . . . . **Basic**

What we pay:
- When you use an in-network dentist **100%**
- When you use an out of network dentist **80%**

How often:
- 1 time per tooth

Other things you should know:
- This is a special material placed underneath a filling to protect the nerve inside the tooth.
- This benefit is available for adult (permanent) teeth only.
- All services associated with a pulp cap, such as X-rays, cultures and tests, local anesthetic, temporary filling, and routine follow up care, will be considered part of the pulp cap.

Pulpotomy . . . . . **Basic**

What we pay:
- When you use an in-network dentist **100%**
- When you use an out of network dentist **80%**

How often:
- As needed

Other things you should know:
- This involves removing the nerve inside the tooth.
- When a root canal is the final treatment, this service will be considered part of the root canal.
- All services for treatment associated with a pulpotomy, such as diagnosis, X-rays, cultures and tests, local anesthetic, protective restoration, and routine follow up care, will be considered part of the pulpotomy.

Apicoectomy, retrograde filling & root amputation . . . . . **Basic**

What we pay:
- When you use an in-network dentist **100%**
- When you use an out of network dentist **80%**

How often:
- 1 time per tooth root for each procedure

Other things you should know:
- An apicoectomy is the surgical removal of the tip of the tooth root.
- A retrograde filling is used to seal the site of the root tip removal.
- A root amputation is the surgical removal of a root from a tooth that has multiple roots.
- All services associated with these procedures, such as diagnosis, X-rays, cultures and tests, local anesthetic, protective restoration, and routine follow up care, will be considered part of the procedure.

Periodontal Care - Treatment of Gum Disease & Related Services

Non-surgical periodontal services

This section explains the benefits available when you receive periodontic care that doesn't involve surgery.

Periodontal maintenance . . . . . **Basic**

What we pay:
- When you use an in-network dentist **100%**
- When you use an out of network dentist **80%**

How often:
- 4 time(s) every calendar year

Other things you should know:
- This is a specialized cleaning that may be needed after any type of previous periodontal treatment. Your dentist may call this a periodontal prophylaxis or periodontal cleaning.
- Periodontal maintenance visits will count toward the number of dental cleanings allowed. Dental cleanings will also count toward the number of periodontal maintenance visits allowed.
- All services associated with periodontal maintenance, including the treatment plan, charting, scaling, polishing, local anesthetic, and post- treatment care, will be considered part of the periodontal maintenance.

Scaling & root planing . . . . . **Basic**

What we pay:
- When you use an in-network dentist **100%**
- When you use an out of network dentist **80%**

How often:
- 1 time(s) per quadrant every 24 months

Other things you should know:
- This is a cleaning of tooth surfaces both above and below the gumline. It may be necessary when there's periodontal disease and chronic inflammation in the gum tissue around the teeth that causes a breakdown in some of the nearby bone.
- This benefit will be available only when there's periodontal disease documented by charting of pockets in the gums and bone loss that's verified by X-ray.
- The upper teeth and the lower teeth are each divided into 2 quadrants, a right side, and a left side.
- All services associated with the scaling and root planing, including the treatment plan, charting, scaling, polishing, local anesthetic, and post-treatment care, will be considered part of the scaling and root planing.

Full mouth debridement . . . . . **Basic**

What we pay:
- When you use an in-network dentist **100%**
- When you use an out of network dentist **80%**

How often:
- As needed

Other things you should know:
- This is an extensive cleaning needed when the teeth can't be examined because of a significant amount of plaque and buildup on them.
- All services associated with the debridement, including the treatment plan, charting, scaling, polishing, local anesthetic, and post-treatment care, will be considered part of the debridement.

Periodontal surgery

This section explains the benefits available when you have periodontic surgery.

Gingivectomy, gingivoplasty (1 to 3 teeth) & crown lengthening . . . . . **Basic**

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **80%**

How often:

- 1 surgical procedure per tooth every 12 months

Other things you should know:

- A gingivectomy and gingivoplasty removes excess or inflamed gum tissue.
- Crown lengthening removes a small amount of bone and gum tissue around a tooth to make a crown fit better.
- This benefit will be available only when there's periodontal disease documented by charting of pockets in the gums and bone loss that's verified by X-ray. This benefit will be available for a gingivectomy of 1 tooth when there is documented inflammation of the gum tissue.
- All services associated with these surgical procedures, including the treatment plan, charting, irrigation, local anesthetic, suturing and post-surgical care, will be considered part of the surgical procedure.

Gingivectomy, gingivoplasty (4 or more teeth), osseous surgery, gingival flap procedure, mesial/distal wedge procedure & surgical revision procedure . . . . . **Basic**

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **80%**

How often:

- 1 surgical procedure per quadrant every 36 months

Other things you should know:

- A gingivectomy and gingivoplasty removes excess or inflamed gum tissue.
- Osseous surgery reshapes the bone around the tooth.
- Gingival flap, mesial/distal wedge and surgical revision procedures reshape the gum tissue around a tooth, teeth, or spaces without teeth.
- This benefit will be available only when there's periodontal disease documented by charting of pockets in the gums and bone loss that's verified by X-ray.
- All services associated with these surgical procedures, including the treatment plan, charting, irrigation, local anesthetic, suturing and post-surgical care, will be considered part of the surgical procedure.

Tissue graft . . . . . **Basic**

What we pay:
- When you use an in-network dentist **100%**
- When you use an out of network dentist **80%**

How often:
- 1 time(s) per tooth or site every 36 months

Other things you should know:
- This involves replacing gum tissue that has been lost around the root area of a tooth.
- This benefit is available only when there's documentation of progressive loss of gum tissue due to disease.
- This benefit is available only when the tooth is present.
- This benefit is available only when this procedure is necessary as part of a covered implant placement.
- All services associated with the graft, including the treatment plan, charting, irrigation, suturing, local anesthetic, and post-surgical care, will be considered part of the graft.

Guided tissue regeneration . . . . . **Basic**

What we pay:
- When you use an in-network dentist **100%**
- When you use an out of network dentist **80%**

How often:
- 1 time(s) per tooth or site

Other things you should know:
- This is used to replace gum tissue. It's frequently done with a bone graft to replace bone that has been lost.
- This benefit will be available only when there's periodontal disease documented by charting of pockets in the gums and bone loss that's verified by X-ray.
- This benefit is available only when the tooth is present.
- All services associated with the regeneration, including the treatment plan, charting, irrigation, suturing, local anesthetic, and post-surgical care will be considered part of the regeneration.

Bone replacement graft . . . . . **Basic**

What we pay:
- When you use an in-network dentist **100%**
- When you use an out of network dentist **80%**

How often:
- 1 time(s) per tooth or site

Other things you should know:
- This involves replacing bone tissue that has been destroyed by periodontal disease.
- This benefit will be available only when there's periodontal disease documented by charting of pockets in the gums and bone loss thats verified by X-ray.
- This benefit is available only when the tooth is present.
- All services associated with the bone graft, including the treatment plan, charting, irrigation, suturing, local anesthetic, and post-surgical care, will be considered part of the bone graft.

Periodontal related services

This section explains the benefits available for other periodontal related services.

Limited occlusal adjustment . . . . . **Basic**

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **80%**

How often:

- As needed

Other things you should know:

- This is a minor adjustment of the biting surfaces of 1 or more teeth.

Occlusal guard . . . . . **Basic**

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **80%**

How often:

- 1 appliance during the lifetime of this Plan

Other things you should know:

- This appliance covers some or all the teeth. There are different types of guards used for different types of treatment.
- This benefit is available only when the guard is received within 6 months after osseous surgery.

Bridges & Dentures - Prosthodontics

Bridges

This section explains the benefits available when you have a bridge made and placed.

Bridges . . . . . **Major**

What we pay:

- When you use an in-network dentist **60%**
- When you use an out of network dentist **50%**

How often:

- 1 time per tooth every 5 years
- For a replacement, the bridge must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:

- This a fixed prosthetic that replaces 1 or more missing teeth and is held in place by adjacent teeth. Your dentist may refer to the false teeth as pontics and to the adjacent teeth as abutments.
- This benefit is available for adult (permanent) teeth only.
- The benefit for a noble metal bridge is available for all teeth. If a more expensive material is used, what we pay will be based on the cost of a noble metal bridge.
- A bridge that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.
- All services associated with a bridge, including insulating bases, temporary or provisional restorations, local anesthetic, or gingival involvement, will be considered part of the bridge.
- The day the tooth is initially prepared for the bridge will be considered the date the service is performed.

Dentures

This section explains the benefits available when you have a denture made and placed.

Dentures - partial & complete . . . . . **Major**

What we pay:

- When you use an in-network dentist **60%**
- When you use an out of network dentist **50%**

How often:

- 1 time every 5 years for each denture
- For a replacement, the denture must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:

- These are removable dental prostheses used to replace missing teeth. A partial denture replaces 1 or more upper teeth or 1 or more lower teeth. A complete denture replaces all the upper teeth or all the lower teeth.
- This benefit is available to replace adult (permanent) teeth only.
- The day the final impression is taken for the denture will be considered the date the service is performed.
- If a temporary, interim, or provisional denture is in place for more than 1 year, it will be considered a permanent denture.
- All services associated with a denture, including a temporary denture and adjustments made in the first 6 months after the denture is placed, will be considered part of the denture.
- A denture that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.

Bridge & denture repairs & maintenance

This section explains the benefits available when a bridge or denture needs to be repaired or modified.

Bridge repairs . . . . . **Major**

What we pay:

- When you use an in-network dentist **60%**
- When you use an out of network dentist **50%**

How often:

- As needed

Other things you should know:

- A bridge may need to be repaired due to wear or other damage.

Denture repairs . . . . . **Major**

What we pay:

- When you use an in-network dentist **60%**
- When you use an out of network dentist **50%**

How often:

- As needed

Other things you should know:

- A denture may need to be repaired due to wear or other damage.

Denture adjustments . . . . . **Major**

What we pay:
- When you use an in-network dentist **60%**
- When you use an out of network dentist **50%**

How often:
- As needed

Other things you should know:
- Adjustments involve making changes to the denture to ensure a proper fit.

Adding teeth to partial dentures . . . . . **Major**

What we pay:
- When you use an in-network dentist **60%**
- When you use an out of network dentist **50%**

How often:
- As needed

Other things you should know:
- A partial denture may need to be modified if additional teeth are lost after it was first placed.

Denture rebase . . . . . **Major**

What we pay:
- When you use an in-network dentist **60%**
- When you use an out of network dentist **50%**

How often:
- As needed

Other things you should know:
- This involves replacing the entire acrylic denture base without replacing the artificial teeth.

Denture reline . . . . . **Major**

What we pay:
- When you use an in-network dentist **60%**
- When you use an out of network dentist **50%**

How often:
- As needed

Other things you should know:
- This involves reshaping the denture base to make it more comfortable.

Tissue conditioning . . . . . **Major**

What we pay:
- When you use an in-network dentist **60%**
- When you use an out of network dentist **50%**

How often:
- As needed

Other things you should know:
- This is a temporary cushion placed inside a denture to improve fit and comfort following an extraction or other surgical procedure.

Dental Implants

Implants

This section explains the benefits available when you have a dental implant placed.

Radiographic/surgical implant index . . . . . **Major**

What we pay:
- When you use an in-network dentist **60%**
- When you use an out of network dentist **50%**

How often:
- 1 time for the upper teeth and 1 time for the lower teeth every 24 months

Other things you should know:
- This is a customized template used to guide the correct placement of the implant.

Surgical placement of implant . . . . . **Major**

What we pay:
- When you use an in-network dentist **60%**
- When you use an out of network dentist **50%**

How often:
- 1 time per tooth every 5 years
- For a replacement, the implant must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:
- An implant is like a post and is surgically placed into the jawbone.
- This benefit is available for adult (permanent) teeth only.
- All services associated with an implant, such as the treatment plan, local anesthetic, and post-surgical care, will be considered part of the implant.
- An implant crown that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.

Other implant related services

This section explains the benefits available for other services related to dental implants.

Implant abutments - prefabricated & custom fabricated . . . . . **Major**

What we pay:

- When you use an in-network dentist **60%**
- When you use an out of network dentist **50%**

How often:

- 1 time per tooth every 5 years
- For a replacement, the implant abutment must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:

- These attach to the implant and connect the implant to the implant crown, bridge, or denture.
- An implant abutment that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.

Implant/abutment-supported crowns . . . . . **Major**

What we pay:
- When you use an in-network dentist **60%**
- When you use an out of network dentist **50%**

How often:
- 1 time per tooth every 5 years
- For a replacement, the implant crown must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:
- These are screwed or cemented onto the abutment to replace the missing tooth.
- This benefit is available for adult (permanent) teeth only.
- The benefit for a noble metal crown is available for all teeth. If a more expensive material is used, what we pay will be based on the cost of a noble metal crown.
- An implant crown that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.

Implant/abutment-supported dentures . . . . . **Major**

What we pay:
- When you use an in-network dentist **60%**
- When you use an out of network dentist **50%**

How often:
- 1 time per denture every 5 years
- For a replacement, the implant denture must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:
- These are used to replace missing teeth. A partial denture replaces 1 or more upper teeth or 1 or more lower teeth. A complete implant denture replaces all the upper teeth or lower teeth.
- This benefit is available to replace adult (permanent) teeth only.
- An implant denture that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.

Bone replacement graft for ridge preservation . . . . . **Major**

What we pay:
- When you use an in-network dentist **60%**
- When you use an out of network dentist **50%**

How often:
- 1 time per tooth or area

Other things you should know:
- This involves replacing bone tissue that has been lost because of an extraction or implant removal.
- This benefit is available only when the procedure is done with a covered dental implant in the same site.

Implant repairs & removal

This section explains the benefits available when you have an implant abutment, crown or denture that needs to be repaired or an implant that needs to be removed.

Implant crown & implant denture repairs . . . . . **Major**

What we pay:
- When you use an in-network dentist **60%**
- When you use an out of network dentist **50%**

How often:
- As needed

Other things you should know:
- An implant supported crown or denture may need to be repaired due to wear or other damage.

Implant abutment repairs . . . . . **Major**

What we pay:
- When you use an in-network dentist **60%**
- When you use an out of network dentist **50%**

How often:
- As needed

Other things you should know:
- An implant abutment may need to be repaired due to wear or other damage.

Implant removal . . . . . **Major**

What we pay:
- When you use an in-network dentist **60%**
- When you use an out of network dentist **50%**

How often:
- 1 time per tooth

Other things you should know:
- This involves removing an implant from the jaw.

Tooth Extractions & Oral Surgery

Extractions

This section explains the benefits available when you have a tooth removed.

Non-surgical extractions . . . . . **Basic**

What we pay:
- When you use an in-network dentist **100%**
- When you use an out of network dentist **80%**

How often:
- As needed

Other things you should know:
- This is done to remove a tooth or root that's above the gumline.
- All services associated with the extraction, such as the treatment plan, local anesthetic, and post-treatment care, will be considered part of the extraction.

Complex surgical extractions . . . . . **Basic**

What we pay:
- When you use an in-network dentist **100%**
- When you use an out of network dentist **80%**

How often:
- As needed

Other things you should know:
- This is done when the extraction involves cutting the gums or bone to remove the tooth or roots.
- All services associated with the extraction, such as the treatment plan, local anesthetic, suturing and post-surgical care, will be considered part of the extraction.
- These procedures may be covered by your medical plan. See the **Other things you should know about claims** section of the Member Guide for more information.

Other oral surgery services

This section explains the benefits available for other oral surgery procedures.

Other complex oral surgeries . . . . . **Basic**

What we pay:
- When you use an in-network dentist **100%**
- When you use an out of network dentist **80%**

How often:
- As needed

Other things you should know:
- Other types of oral surgery may be needed to treat oral diseases, injuries, and defects.
- All services associated with the surgery, such as X-rays, the treatment plan, local anesthetic, suturing, and post-surgical care, will be considered part of the surgery.
- These procedures may be covered by your medical plan. See the **Other things you should know about claims** section of the Member Guide for more information

Other Dental Services

This section explains the benefits available when you receive one of the following services.

Anesthesia . . . . . **Basic**

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **80%**

How often:

- As needed

Other things you should know:

- This is a drug administered during procedures to reduce pain or discomfort. This includes:
  - Deep sedation/general anesthesia
  - Intravenous conscious sedation
  - Non-intravenous conscious sedation
  - Nitrous oxide
- This benefit is available only when the anesthesia is administered with a covered surgical service.

Consultations . . . . . **Preventive**

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:

- As needed

Other things you should know:

- This is an examination performed by a specialty dentist or a dentist other than your usual dentist.

Orthodontic Care

This section explains the benefits available when you have your teeth straightened or realigned.

Orthodontic services . . . . . **Orthodontic**

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- As needed

Other things you should know:

- These services correct the position of the teeth and jaw.
- This benefit is available for adults and children.
- This benefit is available for the orthodontic treatment plan and records, including impressions, X-rays, photographs, study models, braces or clear aligners, periodic visits, and retainers.
- This benefit will be divided into equal payments and will be made over the length of the treatment plan or 2 years, whichever is shorter. The first payment will be made when the appliances are initially placed. The remaining payments will be made at the end of every quarter.
- If the orthodontic treatment began before your coverage under this Plan started, the treatment will be pro-rated. For example, if 40% of the treatment was completed before coverage under this Plan began, only the remaining 60% will be considered.
- The day the appliances are first placed will be considered the date the service begins.
- Discounts offered by dentists in our network aren't available for:
  - Additional charges for optional orthodontic appliances
  - Replacement or repair of an orthodontic appliance needed due to neglect
  - Orthodontic treatment plans that began before you became eligible for benefits for orthodontic services under this plan.
- There's a maximum amount of benefits that will be paid for orthodontic care. See the **Benefit maximums** section for this amount.

What isn’t covered - exclusions

This section explains the services that aren’t covered by this Plan.

No benefits are available for:

- Any service for which there is no charge
- Any service that doesn’t meet professionally recognized standards of dental practice or that’s considered to be experimental
- Any service that’s performed in conjunction with or related to a service that isn’t covered by this guide
- Any service on a tooth with a guarded, questionable, or poor prognosis
- Any service that’s used solely to:
  - Alter occlusal vertical dimensions
  - Restore or maintain occlusion
  - Treat a condition resulting from attrition, abrasion, erosion or abfraction
  - Splint or stabilize teeth for periodontal reasons
- Replacing extracted or missing wisdom teeth
- Localized use of antimicrobial agents into diseased crevicular tissue
- Any service that’s provided solely for cosmetic reasons, such as teeth whitening, characterization, or personalization of a dental prosthesis, or odontoplasty.
- Replacement of a lost, missing, or stolen appliance or dental prosthesis, or the fabrication of a spare appliance or dental prosthesis
- Upgrading from one appliance or dental prosthesis to another appliance or dental prosthesis, such as replacing a bridge with a dental implant or replacing a denture with a bridge
- A temporary or provisional appliance or dental prosthesis, unless it’s an interim partial denture that replaces anterior teeth extracted while this coverage was in place. These are the incisor and cuspid teeth located in the front of the mouth.
- A bridge that replaces the extracted portion of a hemisected tooth
- The placement of more than one crown or bridge unit per tooth
- Overdentures and related services, including root canal therapy on teeth supporting the overdenture
- Detailed and extensive oral evaluations
- Any service that’s educational or instructional, such as oral hygiene instruction, tobacco counseling or nutritional counseling
- Bite registration, bite analysis or occlusion analysis - mounted case
- Duplication of X-rays
- Completion of claim forms
- OSHA or other infection control measures
- Cephalometric X-rays
- Cone beam images
- Oral or facial photographs
- Prescription medication
- Application of desensitizing medications and resins
- Separate charges for local anesthesia
- Pulp vitality tests
- Caries susceptibility tests
- Specialized techniques
- Precision attachments
- Maxillofacial prosthetics to repair facial or skeletal anomalies, maxillofacial surgery, orthognathic surgery, or any oral surgery requiring the setting of a fracture or dislocation that results from or is incidental to a medical condition
- Treatment of congenital or developmental malformations or the replacement of congenitally missing teeth
- Any service intended to treat or diagnose disorders of the temporomandibular joint (TMJ)

- Any service coded by the dentist as unspecified
- The isolation of a tooth with a rubber dam
- Gingival irrigation
- Medications dispensed in a dental office for home use

B651.1249

All Options

Here is a notice to help you better understand your rights if your Plan is governed by ERISA. The notice isn't part of the group insurance policy or member guide.

B651.1025

All Options

Statement of ERISA Rights

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001
(212) 598-8000

Your group Dental benefits may be covered by the Employee Retirement Income Security Act of 1974 (ERISA). If so, you are entitled to certain rights and protections under ERISA.

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

a) Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

b) Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

c) Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforcement of Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules (see Claims Procedures below).

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a state or Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110.00 a day until you receive the material, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a Federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

Assistance with Questions

If you have questions about the plan, you should contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Qualified Medical Child Support Order and Qualified Domestic Relations Order

Federal law required that group health plans provide medical coverage for a dependent child pursuant to a qualified medical child support order (QMCSO). A dependent child also includes a child for whom you must provide Dental Insurance due to a QMCSO as defined in the ERISA Section 609(a) United States Employee Retirement Income Security Act of 1974, as amended.

You and your beneficiaries can obtain, without charge, from the plan administrator, a copy of any procedures governing Qualified Domestic Relations Orders (QDRO) and QMCSO. You may also obtain this information on the U.S. Department of Labor's website or you may contact them in your telephone directory.

A dependent enrolled due to a QMCSO will not be considered a late enrollee in the plan.

If you have questions about this section, see your plan administrator.

Dental Benefits Claims Procedure

Claim forms and instructions for filing claims may be obtained from the plan administrator.

The plan administrator is the Claims Fiduciary with discretionary authority to interpret and construe the terms of the Policy, the Certificate, the Schedule of Benefits, and any riders, or other documents or forms that may be attached to the Certificate or the Policy, and any other plan documents. The plan administrator has discretionary authority to determine eligibility for benefits and coverage under those documents. The plan administrator has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

In addition to the basic claim procedure explained in your certificate, the plan administrator will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of ERISA.

Definitions

"Adverse Benefit Determination" means any denial, reduction or termination of a benefit or failure to provide or make payment (in whole or in part) for a benefit.

Timing for Initial Benefit Determination

The Benefit Determination period begins when a claim is received. The plan administrator, or its designee, will make a Benefit Determination and notify a claimant within a reasonable period of time, but not later than the maximum time period shown below. A written or electronic notification of any Adverse Benefit Determination must be provided.

The plan administrator, or its designee, will provide a Benefit Determination not later than 45 days from the date of receipt of a claim. This period may be extended by up to 30 days if the plan administrator, or its designee, determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period the plan administrator, or its designee, determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies

the claimant, the time period for making a Benefit Determination may be extended for up to an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

A notification of an extension to the time period in which a Benefit Determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

If the plan administrator, or its designee, extends the time period for making a Benefit Determination due to a claimant's failure to submit information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

Adverse Benefit Determination

If a claim is denied, the plan administrator, or its designee, will provide a notice that will set forth:

- The specific reason(s) for the Adverse Benefit Determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information necessary to reconsider the claim and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;
- Identification and description of any specific internal rule, guideline or protocol that was relied upon in making an Adverse Benefit Determination, or a statement that a copy of such information will be provided to the claimant free of charge upon request;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an Adverse Benefit Determination on appeal, and;
- In the case of an Adverse Benefit Determination based on medical necessity or experimental treatment, either an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request.

Appeal of Adverse Benefit Determinations

If a claim is wholly or partially denied, the claimant will have up to 180 days to make an appeal. The plan administrator, or its designee, will conduct a full and fair review of an appeal which includes providing to claimant(s) the following:

- The opportunity to submit written comments, documents, records and other information relating to the claim;
- The opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relevant to the claim; and
- A review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, the plan administrator, or its designee, will:

- Provide for a review conducted by a named fiduciary who is neither the person who made the initial Adverse Benefit Determination nor that person's subordinate;

- In deciding an appeal based upon a dental or medical judgement, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Identify dental or medical experts whose advice was obtained in connection with an Adverse Benefit Determination;
- Ensure that a health care professional engaged for consultation regarding an appeal based upon a professional judgment shall be neither the person who was consulted in connection with the Adverse Benefit Determination, nor that person's subordinate.

The plan administrator, or its designee, will notify the claimant of its decision not later than 45 days after receipt of the request for review of the Adverse Benefit Determination. This period may be extended by an additional period of up to 45 days if the plan administrator, or its designee, determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 45-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event the plan administrator, or its designee, denies the appeal of an Adverse Benefit Determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
- If applicable, provide the internal rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Benefit determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request.

Alternative Dispute Options

The claimant and the plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor Office and the State insurance regulatory agency.

B651.1054

SUMMARY PLAN DESCRIPTION SUPPLEMENT TO CERTIFICATE

You participate in a single or multiple employer insured Welfare Plan. This supplement and your certificate of insurance together may constitute the Summary Plan Description as required by the Employee Retirement Income Security Act of 1974 (ERISA). This supplement should be retained with your certificate.

- **Name of Plan:**

  SANTA CLARA UNIVERSITY Plan

- **Employer's Name:** (Plan Sponsor)

  SANTA CLARA UNIVERSITY

  Address: 500 EL CAMINO REAL
  SANTA CLARA CA 95053

  Phone Number: 408-554-4097

- If you participate in a multiple employer insured Welfare Plan, you may obtain a complete list of the employers sponsoring the plan upon written request to the plan administrator. You may also receive information as to whether a particular employer is a plan sponsor, and if the employer is a plan sponsor, the sponsor's address.

- **IRS Employer Identification Number (EIN):**941156617

- **Plan Number:** 501

- **Type of Administration:**contract administration

- **Plan Administrator:** (if other than Plan Sponsor)

  SANTA CLARA UNIVERSITY

  Address: 500 EL CAMINO REAL
  SANTA CLARA CA 95053

  Phone Number: 408-554-4097

- **Agent for the Service of Legal Process:**

  SANTA CLARA UNIVERSITY

  Address: 500 EL CAMINO REAL
  SANTA CLARA CA 95053

  Phone Number: 408-554-4097

  (Legal process may also be served on the Plan Administrator.)

- If the plan is maintained pursuant to one or more collective bargaining agreements, the following information may be obtained by participants and beneficiaries upon written request to the plan administrator, and is available for examination by participants and beneficiaries: a copy of any such collective bargaining agreement; a complete list of the employers and employee organizations sponsoring the plan; and information as to whether a particular employer or employee organization is a sponsor of the plan, and if so, the sponsor's address. For the purpose of this paragraph, a plan is maintained pursuant to a collective bargaining agreement if such agreement controls any duties, rights or benefits under the plan, even though such agreement has been superseded in part for other purposes.

- **Date of End of Record Year:** January 1st .

- **Sources of Contribution:**Contributions to the plan are provided by:

  - the Employer

  - the Employee

  - Both the Employer and the Employee (assuming there are situations where both contribute).

- A class or classes of full-time employees are eligible to apply for insurance provided they have completed the service waiting period established by the employer, if any. Qualified dependents of these employees may also be eligible for insurance. (Your certificate provides details.)

- Participants and beneficiaries under this Plan can obtain, without charge, a copy of procedures governing qualified domestic relations order (QDRO) determinations from the plan administrator.

- **Termination/Amendment/Elimination:**Conditions may exist in the Group Policy where the plan sponsor or others have the authority to terminate the plan, amend or eliminate benefits under the plan. Please see the Plan Administrator for more information regarding these specific conditions and to request a copy of the Group Policy.

- **Assistance:** For information regarding rights under ERISA, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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