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12/01/2023

GROUP BOOKLET-CERTIFICATE FOR MEMBERS OF

SAN LEANDRO BOYS & GIRLS CLUB

ALL MEMBERS

Group Dental Point of Service (POS) Plan

Print Date: 11/07/2023

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Summary Plan Description for Purposes of Employee Retirement Income Security Act (ERISA):

This booklet-certificate (including any supplement) may be utilized in part in meeting the Summary Plan Description requirements under ERISA for insured employees (or those listed on the front cover) of the Policyholder who are eligible for Group Dental insurance.

A separate booklet-certificate will be issued if necessary to cover one or more separate classes of the Policyholder who are eligible for Group coverage. For further information contact your plan administrator.

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Your insurance has been designed to provide financial help for you when a covered loss occurs. Your employer has chosen benefits provided by a Group Policy issued by Us, Principal Life Insurance Company. To the extent that benefits are provided by that Group Policy, the administration and payment of claims will be done by Us as an insurer.

Members rights and benefits are determined by the provisions of the Group Policy. This booklet briefly describes those rights and benefits. It outlines what you must do to be insured. It explains how to file claims. It is your certificate while you are insured.

The effective date of your insurance is as shown on your enrollment card.

THIS BOOKLET REPLACES ANY PRIOR BOOKLET THAT YOU MAY HAVE RECEIVED. If you have any questions about this new booklet, please contact your employer. In the event of future changes to your coverage, you will be provided with a new booklet-certificate or a booklet-certificate rider.

If you have an electronic booklet, paper copies of this booklet-certificate are also available. Please contact your employer if you would like to request a paper copy.

IMPORTANT: If you choose to receive dental services that are not covered under the Group Policy, a participating dentist may charge you his or her usual and customary rate for those services. Before providing the non-covered services, a dentist should provide the patient with a treatment plan that includes each anticipated service and the estimated cost of each service. If you would like more information about dental coverage options, you may call member services at the number shown on your ID card or your insurance broker.

PLEASE READ YOUR BOOKLET CAREFULLY. We suggest that you start with a review of the terms listed in the DEFINITIONS Section (at the back of the booklet). The meanings of these terms will help you understand the insurance.

This booklet describes all the benefits available under the Group Policy underwritten by Us. However, if you have elected to not accept any available benefits, those benefits described in this booklet will not apply to you.

The group insurance policy and your coverage under the Group Policy may be discontinued or altered by the Policyholder or Us at any time without your consent.

The insurance provided in this booklet is subject to the laws of the state of CALIFORNIA.

No Cost Language Services. You can get an interpreter and get documents read to you in your language. For help, call us at the number listed on your ID card or 1-800-247-4695. For more help call the CA Dept. of Insurance at 1-800-927-4357.

PRINCIPAL LIFE
INSURANCE COMPANY
Des Moines, IA 50392-0002

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SUMMARY OF BENEFITS
(revised effective December 1, 2023)

DENTAL EXPENSE INSURANCE

This section highlights the benefits provided under this insurance. The purpose is to give you quick access to the information you will most often want to review. **Please read the other sections of this booklet for a more detailed explanation of your benefits and any limitations or restrictions that might apply.**

If you or one of your Dependents receive dental Treatment or Service listed under the Schedule of Dental Procedures, Scheduled Benefits then in force will be payable. Scheduled Benefits are based on your class and the status of your Dependents:

Class	Scheduled Benefit
Members and their Dependents	All benefits for Covered Charges under Dental Care Units 1, 2, and 3.

Point of Service (POS) Plan

Your Policyholder participates in a Point of Service (POS) Plan administered by Us.

As you may know, Point of Service (POS) Plans are the most versatile type of plan and provide two to three tiers (points) of coverage. An insured person covered under a Point of Service (POS) plan can move between these different tiers of coverage each time dental care is received.

It is expected that your Policyholder's participation in the POS Plan will result in significant savings of funds needed to maintain your insurance. These savings are to be passed on to you in the form of higher plan benefits payable for services received by you or a Dependent from Exclusive Providers and Preferred Providers.

Please note that your Policyholder's participation in the POS Plan does not mean that your choice of provider will be restricted. You may still seek needed dental care from any Dentist you wish. However, in order to avoid higher charges and reduced benefits payments, you are urged to obtain such care from Exclusive Providers or Preferred Providers whenever possible.

A current listing of the participating providers is available through an on-line Exclusive Provider or Preferred Provider directory. By accessing the Principal Life Insurance Company website www.principal.com, you can review provider directories for your EPO or PPO Network. Click on "Provider Directory," then "Search for a Dental Provider," then you can continue to follow the prompts to find your EPO or PPO network. If you do not have Internet access, you can request a paper copy of the provider directory for your EPO and PPO network from (800) 554-3392 for dental providers. Whether using the Internet or a paper directory, we recommend that you (1) verify your provider's participation in the network before seeking treatment and (2) confirm EPO or PPO participation with your provider when making your appointment.

Dental Care Units

The type of Treatment or Service covered under each of the Dental Care Units is:

Preventive Procedures	Unit 1
Basic Procedures	Unit 2
Major Procedures	Unit 3

Benefits Payable

Benefits payable for each insured person will be the percent of Covered Charges shown below, and will vary depending upon whether or not needed care is received from a Preferred Provider.

Covered Charges will be the actual cost charged to you or your Dependent for Treatment or Service for the listed procedures shown in the SCHEDULE OF DENTAL PROCEDURES Section but only to the extent that the actual cost charged does not exceed Prevailing Charges.

Dental benefits payable for Treatment or Services received will be:

Service	EPO Providers	PPO Providers	Non-EPO Providers/Non-PPO Providers
Dental Care Unit 1			
Preventive Procedures			
Coinsurance	100%	100%	100%
Individual Deductible	None	None	None
Dental Care Unit 2			
Basic Procedures			
Coinsurance	90%	90%	90%
Individual Deductible	$50 per Calendar Year (Units 2 and 3 combined)	$50 per Calendar Year (Units 2 and 3 combined)	$50 per Calendar Year (Units 2 and 3 combined)
Family Maximum Deductible	$150 per Calendar Year (Units 2 and 3 combined)	$150 per Calendar Year (Units 2 and 3 combined)	$150 per Calendar Year (Units 2 and 3 combined)
Dental Care Unit 3			
Major Procedures			
Coinsurance	60%	60%	60%
Individual Deductible	$50 per Calendar Year (Units 2 and 3 combined)	$50 per Calendar Year (Units 2 and 3 combined)	$50 per Calendar Year (Units 2 and 3 combined)
Family Maximum Deductible	$150 per Calendar Year (Units 2 and 3 combined)	$150 per Calendar Year (Units 2 and 3 combined)	$150 per Calendar Year (Units 2 and 3 combined)

Treatment or Service not Available from a Preferred Provider

If Treatment or Service for a listed Covered Charge is not available through a Preferred Provider, and you or your Dependent receive such Treatment or Service from a Non-Preferred Provider, benefits for such Treatment or Service will be paid as if a Preferred Provider had provided the Treatment or Service.

Telehealth Services

If Treatment or Service for a listed Covered Charge is appropriately delivered through telehealth services, benefits for such Treatment or Service will be paid on the same basis as if the Treatment or Service was provided in person.

Deductible Amount(s)

- You pay an individual Deductible Amount for each insured person for dental Treatment or Service received under each Dental Care Unit for a Calendar Year. The individual Deductible Amount will be the amount shown above. After you satisfy the Deductibles, We will pay Covered Charges at the rate indicated for each Dental Care Unit.

- For each Dental Care Unit, Covered Charges used to satisfy the Deductible that is applicable when care is received from Non-Exclusive Providers/Non-Preferred Providers for the Calendar Year will be counted toward satisfaction of the Deductible that is applicable when care is received from Exclusive Providers and Preferred Providers for the Calendar Year, and vice versa.

- In no event will the individual Deductible for combined Exclusive Providers, Preferred Providers, Non-Exclusive Providers and Non-Preferred Providers be more than the Non-Exclusive and Non-Preferred Providers Deductible Amount for the Calendar Year.

- Charges are applied to the Deductible Amount in the order in which they are incurred. However, if Covered Charges are incurred for Units 1, 2, and 3 on the same date, the charges will be applied to the Deductible Amount in the following order:

    - first, to Unit 1 charges; and

    - then, to Unit 2 charges; and

    - last, to Unit 3 charges.

- In place of individual Deductibles, a family maximum Deductible may be applied. When this family maximum is satisfied for a Calendar Year, Dental benefits will be payable as if the individual Deductibles had been satisfied for each person in your family. The family maximum Deductible each Calendar Year will be the amount shown above (but not counting more than $150 of such Covered Charges for each person in your family).

Maximum Payment Limit

(Applies to combined charges for Treatment or Service received from Exclusive Providers, Preferred Providers, Non-Exclusive Providers and Non-Preferred Providers.)

The Dental Maximum Payment Limits for you and for each of your Dependents will be:

- Dental Care Units 1, 2, and 3 $2,000 each Calendar Year for dental care received from Exclusive Providers and $2,000 each Calendar Year for dental care received from Preferred Providers and $2,000 each Calendar Year for dental care received from Non-Exclusive Providers/Non-Preferred Providers.

Covered Charges used to satisfy the maximum that applies when care is received from Exclusive Providers will be used in combination with care received from Preferred Providers and Non-Exclusive Providers/Non-Preferred Providers to satisfy the maximum.

For Dental Care Unit(s) 1, 2 and 3, at the end of each Calendar Year, if you or your Dependent have:

- received at least one procedure performed during that Calendar Year; and
- used $1,000 or less of benefits during the Calendar Year;

the balance of any unused benefits or any difference between paid claims and up to 50% of $1,000 for each insured person will carry-over ("roll-over") into the next Calendar Year. These benefits will be combined with the Maximum Payment Limit for the current Calendar Year and will be payable at the same level up to a maximum amount of $2,000. In the event that an insured person does not receive at least one procedure in any year, any current or previous amount carried over for that insured person would be forfeited.

This carry-over provision does not apply:

- during the first Calendar Year for any individual having an initial coverage effective date in October, November or December; or
- until all waiting periods have been satisfied.

Benefit Advice

A benefit consulting service is available for you and your Dependents to provide information about the best use of your dental benefits. Examples of information you may find helpful include:

- general information on types of services offered by various dental care providers; and
- specific information such as benefits available for a particular dental procedure.

Call Our toll-free number (see your ID card or your employer for the number to call) if you wish to discuss dental benefits with Our benefit consultants.

HOW TO BE INSURED - MEMBERS

DENTAL EXPENSE INSURANCE

Eligibility

To be eligible for insurance you must be a Member.

Member means any PERSON who is a Full-Time Employee of the Policyholder.

You will be eligible on the first of the Insurance Month next following the date you begin Active Work.

If you elect to waive insurance under the Group Policy because you are covered under group dental expense coverage or coverages provided by your Dependent's employer, the date such coverage terminates because your Dependent is no longer eligible under his/her employer's coverage will be considered the date you are eligible to request insurance as described in this section.

Effective Dates - Actively at Work

If you are not Actively at Work on the date your insurance would otherwise be effective, your insurance will not be in force until the day you return to Active Work.

This Actively at Work requirement will be waived for you if:

- you are absent from Active Work because of a regularly scheduled day off, holiday, or vacation day; and
- you were Actively at Work on your last scheduled work day before the date of your absence; and
- you were capable of Active Work on the day before the scheduled effective date of your insurance or change in your insurance, whichever is applicable.

Individual Incontestability and Eligibility

All statements made by any person insured (you or one of your Dependents) will be representations and not warranties. In the absence of fraud, these statements may not be used to contest the insured person's insurance unless:

- the insurance has been in force for less than two years during the insured person's lifetime; and
- the statement is in Written form Signed by the insured person; and
- a copy of the form which contains the statement is given to the insured person or the insured person's beneficiary at the time insurance is contested.

However, the above will not preclude the assertion at any time of defenses based upon the person's not being eligible for insurance under the Group Policy or upon other provisions of the Group Policy.

In addition, if a person's age is misstated, We may, at any time, adjust premiums and benefits to reflect the correct age.

We may at any time terminate a person's eligibility under the Group Policy:

- in Writing and with 31-day notice, if the individual submits any claim that contains false or fraudulent elements under state or federal law; or

- in Writing and with 31-day notice, upon finding in a civil or criminal case that an individual has submitted claims that contain false or fraudulent elements under state or federal law; or

- in Writing and with 31-day notice, when an individual has submitted a claim which, in good faith judgment and investigation, an individual knew or should have known, contains false or fraudulent elements under state or federal law.

Effective Date for Noncontributory Insurance

Insurance for which you contribute no part of the premium will become effective on the date you are eligible.

Effective Date for Contributory Insurance

If you are required to contribute towards the cost of your insurance, you must request insurance in a form approved by Us. The requested insurance will become effective on:

- the first of the Insurance Month coinciding with or next following the date you are eligible, if the request is made on or before that date; or

- the first of the Insurance Month coinciding with or next following the date you are eligible, if you make your request within 31 days after the date you are eligible; or

- the Policy Anniversary date following the date of your request, if you make your request more than 31 days after the date you are eligible.

However, if you are not Actively at Work on the date insurance would otherwise be effective, your insurance will not be in force until the date you return to Active Work.

Annual Enrollment Period

An Annual Enrollment Period will be available for any Member or Dependent who failed to enroll:

- during the first period in which he or she was eligible to enroll, or during any subsequent Special Enrollment Period as described below; or

- during any previous Annual Enrollment Period; or

- within 31 days after the termination date, if the individual was previously insured under the Group Policy but elected to terminate the insurance.

To qualify for enrollment during the Annual Enrollment Period, you or your Dependent:

- must meet the eligibility requirements described in the Group Policy, including satisfaction of any applicable waiting period; and

- may not be covered under an alternate dental expense coverage offered by the Policyholder, unless the Annual Enrollment Period happens to coincide with a separate open enrollment period established for coverage election.

The Annual Enrollment Period is generally the one-month period immediately prior to the Policy Anniversary date or another period of time requested by the Policyholder and approved by Us.

The effective date for any qualified individual requesting insurance during the Annual Enrollment Period will be the Policy Anniversary date following completion of the Annual Enrollment Period provided contribution has been received for the requested insurance.

Court Ordered Coverage Under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN): This section will apply to you or your Dependent Child if:

- you are enrolled (or eligible to be enrolled but have failed to enroll during a previous enrollment period); and
- you failed to enroll your Dependent Child during a previous enrollment period; and
- you are required by a QMCSO or NMSN as defined by applicable federal law and state insurance laws to provide dental coverage to your Dependent Child.

The request for enrollment:

- may be made at any time after the issue date of the QMCSO or NMSN; and
- will apply only to you and/or your Dependent Child(ren) listed in the QMCSO or NMSN.

The effective date for your or your Dependent Child's insurance:

- will be the first of the Insurance Month coinciding with or next following the date of the request for enrollment; and
- will not be subject to the Actively at Work provisions described in this section.

A request for enrollment for any Dependent not listed in the QMCSO or NMSN will be subject to the regular effective date provisions of the Group Policy.

A copy of the procedures governing qualified medical child support orders (QMCSO) can be obtained from the plan administrator without charge.

Special Enrollment Period

A Special Enrollment Period, as described below, will be available for you or your Dependent if enrollment is made after the first period in which you or your Dependent are eligible to enroll.

The Special Enrollment Periods are:

- Loss of Other Coverage: A Special Enrollment Period will apply to you or your Dependent if all of the following conditions are met:

  (i) the individual was covered under another group dental expense coverage at the time of his or her initial eligibility, and declined enrollment solely due to the other coverage; and
  (ii) the other coverage terminated due to loss of eligibility (including loss due to divorce or legal separation, termination of a state registered domestic partnership, termination of a Domestic Partner relationship, death, termination of employment or reduction in work hours, or if the other coverage was under a COBRA or state continuation provision, due to exhaustion of the continuation); and
  (iii) request for enrollment is made within 31 days after the other coverage terminates.

  The effective date of insurance will be the first of the Insurance Month coinciding with or next following the date of the request for enrollment provided contribution has been received for the requested insurance.

  NOTE: For the purpose of (ii) above:

  "Loss of eligibility" does not include:

(i) a loss due to failure of the individual to pay premiums on a timely basis or termination of insurance for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the dental expense coverage); or
(ii) a loss due to a spouse's or state registered domestic partner's or Domestic Partner's voluntary termination of his or her dental expense coverage; or
(iii) a loss due to a spouse's or state registered domestic partner's or Domestic Partner's voluntary termination of his or her Dependent dental expense coverage.

- Newly Acquired Dependents: A Special Enrollment Period will apply to you or your Dependent if:

(i) you are enrolled (or are eligible to be enrolled but have failed to enroll during a previous enrollment period); and
(ii) a person becomes your Dependent through marriage, establishment of a state registered domestic partnership, or declaration of a Domestic Partner relationship, birth, adoption or Placement for Adoption; and
(iii) request for enrollment is made within 31 days after the date of the marriage, establishment of a state registered domestic partnership, or declaration of a Domestic Partner relationship, birth, adoption or Placement for Adoption, or the date Dependent Dental Expense Insurance is available to the Member under the Group Policy, if the request is made on or before the event or within 31 days after the event.

The effective date of your or your Dependent's insurance will be:

(i) in the event of marriage or establishment of a state registered domestic partnership, or declaration of a Domestic Partner relationship, the date of such marriage or establishment of a state registered domestic partnership, or declaration of a Domestic Partner relationship; or
(ii) in the event of a Dependent Child's birth, the date of such birth; or
(iii) in the event of a Dependent Child's adoption or Placement for Adoption, the date of such adoption or Placement for Adoption, whichever is earlier.

Effective Date for Benefit Changes

A change in your Scheduled Benefits amount because of a change in your status (insurance class) will normally be effective on the first of the Insurance Month coinciding with or next following the date of the change in status.

A change in your Scheduled Benefit amount because of a change in benefits provided under the Group Policy will normally be effective on the first of the Insurance Month coinciding with or next following the date of the change.

However, if you are not Actively at Work on the date the change would otherwise be effective, the change will not be in force until the day you return to Active Work.

Termination

Unless continued as provided below or on GH 1105 A, GH 1105 B, GH 1105 C, and GH 1105 D, your insurance under the Group Policy will cease on the earliest of:

- the date the Group Policy terminates; or
- the end of the Insurance Month for which the last contribution is made for your insurance; or
- for contributory insurance the end of any Insurance Month desired, if requested by you before that date; or
- the end of the Insurance Month in which you cease to belong to a class for which insurance is provided; or
- the end of the Insurance Month in which you cease to be a Member; or

- the end of the Insurance Month in which you cease Active Work.

Continuation

If you cease Active Work because of sickness or injury, you may be eligible for limited continuation of insurance until the earlier of the date you recover or the date insurance would otherwise terminate as described above.

If you cease Active Work because of layoff or leave of absence, insurance may be continued on a limited basis.

In addition, by paying the required contribution, if any, your insurance may be continued under the continuation provisions described on GH 1105 A, GH 1105 B, GH 1105 C, and GH 1105 D.

If you are interested in continuing your insurance beyond the date it would normally terminate, you should consult with the Policyholder before your insurance terminates.

HOW TO BE INSURED - DEPENDENTS

DENTAL EXPENSE INSURANCE

Eligibility

You will be eligible for insurance for your Dependents on the later of:

- the date you are eligible for Member insurance; or
- the date you first acquire a Dependent.

If your Dependent is employed and is covered under group dental expense coverage or coverages provided by your Dependent's employer, the date such coverage is terminated because your Dependent is no longer eligible under his/her employer's coverage will be considered the date you first acquire that Dependent (and any other Dependent who was also covered under such group coverage or coverages).

Effective Date

Dependent insurance is available only with respect to Dependents of Members currently insured for Member Insurance. If a Member is eligible for Dependent insurance, such insurance for your Dependents will become effective under the same terms as described earlier for Member insurance, except:

- A Dependent acquired after your Dependent insurance is already in force will be insured on the date acquired.
- The Actively at Work requirement does not apply to your Dependents.

Automatic Insurance for Newborns and Newly Adopted Children

If, while your Member Dental Expense Insurance is in force, you acquire a Dependent Child less than 31 days of age or a newly adopted child, that child will be automatically insured for dental benefits on the date the child becomes a Dependent whether or not you have applied for Dependent insurance.

If you are already insured for Dependent insurance, no further application is required to continue the child's insurance. If you are not already insured for Dependent insurance, you must apply (and pay any required contributions) before the date the child attains 31 days of age or for a newly adopted child, within 31 days after the date of Placement for the purpose of adoption, in order to continue the child's insurance beyond that date.

Insurance for a Domestic Partner

If a Member requests insurance for a Domestic Partner, insurance for a Domestic Partner will be in force on the later of:

- the date insurance would otherwise become effective for a Dependent under the terms of the Group Policy; or
- the date We approve the Domestic Partner's status as a Dependent.

Individual Incontestability and Eligibility

Your Dependents will be subject to the Individual Incontestability and Eligibility as described earlier for Member insurance.

Termination

Unless continued as provided below or on GH 1105 A, GH 1105 B, GH 1105 C, and GH 1105 D, insurance for all of your Dependents will terminate on the earlier of:

- the end of the Insurance Month in which you cease to belong to a class for which Dependent Insurance is provided; or

- the date Dependent insurance is removed from the Group Policy; or

- the date your Member insurance ceases.

Insurance for any one Dependent will terminate on the earlier of:

- the last day of the Insurance Month in which he or she ceases to be your Dependent. However, a spouse or state registered domestic partner who no longer resides with the Member will not cease to be a Dependent until legally separated or divorced, or termination of state registered domestic partnership, provided the spouse or state registered domestic partner otherwise provided the spouse otherwise continues to be a Dependent; or

- for each Domestic Partner or Domestic Partner's Dependent Child, on the last day of the Insurance Month in which that Domestic Partner or Domestic Partner's Dependent Child ceases to be a Dependent. However, a Domestic Partner who no longer resides with the Member will not cease to be a Dependent until the Declaration of Termination of Domestic Partnership has been received by Us, provided the Domestic Partner otherwise continues to be a Dependent.

However, Dental Expense Insurance will be continued beyond the maximum age for a Dependent Child who is incapable of self-support because of a Developmental Disability or Physical Handicap and is dependent on you for primary support. You must apply for this continuation within 60 days after the date We notify you that the child is reaching the maximum age.

Continuation

In addition, under certain conditions, your Dependent's Dental Expense Insurance may be continued after the date it would normally terminate. See the continuation provisions described on page GH 1105 A, GH 1105 B, GH 1105 C, and GH 1105 D.

CONTINUATION OF COVERAGE

State Required Continuation - California: Member

State Required Notice:

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

Cal-COBRA - (Applicable only to small employer groups who have at least two but not more than 19 employees and are not subject to COBRA)

- **Definitions**

  Qualified Person means a Member or any covered Dependent who, on the day before a Qualifying Event, is insured under the Group Policy and any child born to or placed for adoption with the Member who is on continuation.

  Qualifying Event means, except for the election to continue insurance, insurance would cease due to the Member's termination of employment or reduction in work hours for reasons other than gross misconduct.

- **Qualification for Continuation**

  Qualified Persons, who would lose insurance under the Group Policy because of a Qualifying Event, may elect to continue insurance on the date insurance would otherwise cease if:

  - the Group Policy is in force; and
  - the Qualified Person timely elects to continue insurance and agrees to pay the required premium; and
  - the Qualified Person is not entitled to Medicare; and
  - the Qualified Person is not covered under any other dental plan in which the preexisting exclusion provisions have been satisfied; and
  - the Qualified Person is not covered or eligible for COBRA.

- **Period of Continuation**

  Insurance for the Qualified Person may be continued until the earliest of:

  - the date the Group Policy is terminated; or
  - the date insurance would otherwise cease as provided in the Group Policy; or
  - the end of the period for which premium is paid, if payment of the required premium is not made within the Grace Period; or
  - the date the Qualified Person becomes entitled to Medicare; or
  - the date the Qualified Person becomes covered under any other dental plan and has satisfied the preexisting exclusion provision (if any); or

- the date the Qualified Person becomes covered or eligible for COBRA; or

- the date insurance has been continued for 36 months.

For a Member's child who is born to or placed for adoption with the Member while on continuation, the maximum continuation period for that child will be the Member's maximum continuation period.

- **Notice, Election, and Premium Requirements**

We will notify a Qualified Person of the availability to continue insurance within 14 days after receiving a Qualifying Event notice. The notification will include premium information and an election form and will be mailed to the Qualified Person's last known address.

Qualified Persons must make written election and deliver the election notice by first class mail (or other reliable means) to Us. The election must be made within 60 days following the date insurance would otherwise cease due to a Qualifying Event, or the date of the notice from Us, whichever is later. Failure to elect continuation within the 60-day period will disqualify the Qualified Person from continuation.

Qualified Persons must notify Us within 30 days of the date a child is born to or placed for adoption with the Member.

If the Group Policy terminates, Qualified Persons may elect to complete the remaining continuation period under the Policyholder's replacing plan, if any. Qualified Persons must elect continuation and pay the required payment within 30 days after receiving the replacing carrier's notice.

Premium charged for the continuation will be 110% of the applicable group rate. The first premium payment must be delivered to Us by first class or certified mail (or other reliable means) within 45 days after the date continuation is elected. The first premium payment must be sufficient to pay all required payments. Failure to make the first payment as required will disqualify the Qualified Person from continuation. All subsequent payments are due monthly on or before the due date. Failure to make the required premium within the Grace Period will disqualify the Qualified Person from continuation.

State Required Continuation - California: Dependents

Cal-COBRA (Applicable only to small employer groups who have at least two but not more than 19 employees and are not subject to COBRA)

- **Definitions**

Qualified Person means a Dependent who, on the day before a Qualifying Event, is covered under the Group Policy as a Dependent spouse, state registered domestic partner or Domestic Partner, or Dependent Child of a Member.

Qualifying Event means any of the following events which, except for the election to continue coverage, would result in a loss of coverage to a Qualified Person:

- the Member's death; or

- the Member's divorce or legal separation from his or her spouse; or

- the Member's termination from his or her state registered domestic partnership or Domestic Partnership; or

- the Member's option to terminate coverage under the Group Policy when he or she becomes entitled to Medicare; or

- a Member's child ceasing to be a Dependent Child as defined in the Group Policy.

- **Qualification for Continuation**

A Qualified Person who would lose insurance under the Group Policy because of a Qualifying Event may elect to continue insurance on the date insurance would otherwise cease if:

- the Group Policy is in force; and
- the Qualified Person timely elects to continue insurance and agrees to pay the required premium; and
- the Qualified Person is not entitled to Medicare; and
- the Qualified Person is not covered under any other dental plan in which the preexisting exclusion provisions have been satisfied; and
- the Qualified Person is not covered or eligible for COBRA.

- **Period of Continuation**

Insurance for the Qualified Person may be continued until the earliest of:

- the date the Group Policy is terminated; or
- the date insurance would otherwise cease as provided in the Group Policy; or
- the end of the period for which premium is paid, if payment of the required premium is not made within the Grace Period; or
- the date the Qualified Person becomes entitled to Medicare; or
- the date the Qualified Person becomes covered under any other dental plan and has satisfied the preexisting exclusion provision (if any); or
- the date the Qualified Person becomes covered or eligible for COBRA; or
- the date insurance has been continued for 36 months.

- **Notice, Election and Premium Requirements**

Qualified Persons must notify Us within 60 days of any Qualifying Event. To assist in providing notice, Qualified Persons may complete and mail to Us the "Notice of Occurrence of a Qualifying Event" form in this section. Failure to notify Us within the 60-day period will disqualify Qualified Persons from continuation.

We will notify Qualified Person within 14 days after receiving a Qualifying Event notice of the availability to continue insurance. The notification will include premium information and an election form and will be mailed to the Qualified Person's last known address.

Qualified Persons must make written election and deliver the election notice by first class mail (or other reliable means) to Us. The election must be made within 60 days following the date insurance would otherwise cease due to a Qualifying Event, or the date of the notice from Us, whichever is later. Failure to elect continuation within the 60-day period will disqualify the Qualified Person from continuation.

If the Group Policy terminates, Qualified Persons may elect to complete the remaining continuation period under the Policyholder's replacing plan, if any. Qualified Persons must elect continuation and pay the required payment within 30 days after receiving the replacing carrier's notice.

Premium charged for the continuation will be 110% of the applicable group rate. The first premium payment must be delivered to Us by first class or certified mail (or other reliable means) within 45 days after the date continuation is elected. The first premium payment must be sufficient to pay all required payments. Failure to make the first payment as required will disqualify the Qualified Person from continuation. All subsequent payments are due monthly on or before the due date. Failure to make the required premium within the Grace Period will disqualify the Qualified Person from continuation.

If the Group Policy is subject to another state-required continuation law this continuation period will be concurrent with any other state-required continuation period.

Continuation for state registered domestic partners (and any Dependent Children)

A. Qualified Persons/Qualifying Events

Continuation of group dental coverage will be offered to the following persons if the person is not covered or eligible for federal continuation (COBRA), the Group Policy is in force, the person was insured under the Group Policy on the day before a qualifying event and the person would otherwise lose that coverage as a result of the following qualifying events:

(1) an insured state registered domestic partner (and any Dependent Children) following the Member's:

(i) termination of employment for a reason other than gross misconduct; or
(ii) a reduction in work hours.

Reduction in work hours includes, but is not limited to, leave of absence, layoff, continuation due to sickness or injury, or when applicable, retirement.

(Note: In this instance, the Member must elect and become covered under COBRA in order for an insured state registered domestic partner to qualify for this group dental continuation); and

(2) a Member's former state registered domestic partner (and any Dependent Children) following the Member's termination from his or her Domestic Partnership; and

(3) a Member's surviving state registered domestic partner (and any Dependent Children), following the Member's death; and

(4) a Member's state registered domestic partner (and any Dependent Children) following the Member's entitlement to Medicare.

B. Maximum Continuation Period

Following a qualifying event, dental coverage can continue up to the maximum continuation period. The maximum continuation period for an insured state registered domestic partner following the Member's termination of employment or reduction in work hours is 18 months from the date of the qualifying event or the date the Member is no longer covered under COBRA, whichever occurs first.

Following the Member's termination of employment or reduction in work hours, a qualified person may request an 11-month extension of this group dental continuation. The maximum group dental continuation will be 29 months from the date of the qualifying event (see Disabled Extension, Section D).

When a Member becomes entitled to Medicare before his or her employment terminates or work hours are reduced, the maximum continuation period for the insured state registered domestic partner will be the longer of:

(1) 36 months dating back to the Member's entitlement to Medicare; or

(2) 18 months from the date of the qualifying event (Member's termination of employment or reduction in work hours).

The maximum continuation period for a qualified person following a qualifying event described in A (2) through A (4) is 36 months from the date of the qualifying event.

C. Second Qualifying Events

If during an 18-month continuation period (or, 29 months for a qualified person on the disabled extension), a second qualifying event described in A (2) through A (4) occurs, the maximum continuation period may be extended for the qualified person up to 36 months. That is, following a second qualifying event, a qualified person may continue for up to a maximum of 36 months dating from the Member's termination of employment or reduction in work hours. The extension is only available if the second qualifying event described in A (2) through A (4), absent the first qualifying event, would result in a loss of coverage for the covered state registered domestic partner under the Group Policy.

D. Disabled Extension

Following a Member's termination of employment or reduction in work hours, a qualified person who has been determined disabled by the Social Security Administration either before or within 60 days after the qualifying event may request an extension of the continued coverage from 18 months to 29 months.

The 11-month extension for a qualified person will end the earlier of (a) 30 days following the date the disabled person is no longer determined by Social Security to be disabled, or (b) the date continuation would normally end as outlined in Section E below.

E. Termination of Continued Coverage

Continued coverage ends the earliest of the following:

(1) the date the maximum continuation period ends; or

(2) the date the qualified person enrolls in Medicare; however, this does not apply to a person who is already enrolled in Medicare on the date he or she elects this group dental continuation or to a person who is on this group dental continuation due to the employer's bankruptcy filing as described in A (5); or

(3) the end of the last coverage period for which payment was made if payment is not made prior to the expiration of the grace period. (See Grace Period, Section I.); or

(4) the date the Group Policy is terminated; or

(5) the date insurance would otherwise cease under the Group Policy; or

(6) the date the qualified person becomes covered by and has satisfied the preexisting exclusion provision of another group dental plan; however, this does not apply to a person who is already covered by the other group dental plan on the date he or she elects this group dental continuation; or

(7) the date the Member is no longer covered under COBRA as described in A (1).

Note: Persons who, after the date of this group dental continuation election, become entitled to Medicare or become covered under another group dental plan and have satisfied the preexisting exclusion provision, are not eligible for continued coverage.

F. Employer/Plan Administrator Notification Requirement

When a covered state registered domestic partner has a qualifying event due to the Member's termination of employment, the Member's reduction in work hours, death of the Member, the Member's entitlement to Medicare, or for retired Members, the commencement of the employer's Chapter 11 (United States Code) bankruptcy proceedings, the employer must notify the plan administrator within 30 days of the date of the qualifying event. The plan administrator must notify the qualified person of the right to this group dental continuation within 14 days after receiving notice of a qualifying event from the employer.

G. Qualified Person Notice and Election Requirement

A qualified person must notify the plan administrator in writing within 60 days after (a) the date of a qualifying event (i.e., Member's termination from his or her state registered domestic partnership under the terms of the Group Policy); (b) the date the qualified person would otherwise lose coverage as a result of a qualifying event; or (c) the date the qualified person is first informed of this notice obligation; otherwise the right to this group dental continuation ends. This 60-day notice period applies to initial and second qualifying events.

A qualified person who requests an extension of this group dental continuation due to disability must submit a written request to the plan administrator before the 18-month group dental continuation period ends and within 60 days after the latest of the following dates: (a) the date of disability determination by the Social Security Administration; (b) the date of the qualifying event; (c) the date the qualified person would otherwise lose coverage as a result of a qualifying event; or (d) the date the qualified person is first informed of this notice obligation; otherwise the right to the disabled extension ends. A qualified person must also notify the plan administrator within 30 days after the date the Social Security Administration determines the qualified person is no longer disabled.

Notification of a qualifying event to the plan administrator must be in Writing and must include the following information: (a) name and identification number of the Member and the qualified person; (b) type and date of initial or second qualifying event; (c) if the notice is for an extension due to disability, a copy of any letters from the Social Security Administration and the Notice of Determination; and (d) the name, address and daytime phone number of the qualified person (or legal representative) that the plan administrator may contact if additional information is needed to determine group dental continuation rights.

Within 14 days after receiving notice of a qualified event from the qualified person, the plan administrator must provide the qualified person with an election notice and premium information.

A qualified person must make written election within 60 days after the later of: (a) the date group dental coverage would normally end; or (b) the date of the plan administrator's election notice. The election notice must be returned to the plan administrator within this 60-day period; otherwise the right to elect group dental continuation ends.

To protect group dental continuation rights, the plan administrator must be informed of any address changes for a covered state registered domestic partner. Retain copies of any notices sent to the plan administrator.

H. Monthly Cost

A qualified person electing continued coverage can be required to pay 102% of the cost for the applicable coverage.

I. Grace Period

A qualified person has 45 days after the initial election to remit the first payment. The first payment must include all payments due when sent. All other payments (except for the first payment) will be timely if made within the Grace Period. "Grace Period" means the first 60-day period following a premium due date. Except for the first payment, a Grace Period of 60 days will be allowed for payment of premium. Continued coverage will remain in effect during the Grace Period provided payment is made prior to the expiration of the Grace Period. If payment is not made prior to the expiration of the Grace Period, continued coverage will terminate at the end of the last coverage period for which payment was made.

J. Policy Changes

Continued coverage will be subject to the same benefits and rate changes as the Group Policy.

K. Contact Information

To notify the plan administrator of an initial or second qualifying event, request a disabled extension, request termination of group dental continuation, change of address, or request additional information concerning the Group Policy or group dental continuation, contact the following:

Group Dental Plan:	SAN LEANDRO BOYS & GIRLS Dental Plan
Contact Name/Area:	SAN LEANDRO BOYS & GIRLS Benefits Department
Address:	401 MARINA BLVD SAN LEANDRO CA 94577
Phone Number:	510-483-5581

If coverage under this Group Policy is continued under a state continuation mandate, the continuation coverage provided under this subsection will run concurrently with the state continuation period.

NOTICE OF OCCURRENCE OF A Cal-COBRA QUALIFYING EVENT

In order to continue dental insurance under the Group Policy, Principal Life Insurance Company must be notified of the occurrence of a Qualifying Event. For this purpose, Qualified Persons must complete this form and mail by first class mail (or other reliable means) to the address below within 60 days after the date of the Qualifying Event. Failure to provide notice of a Qualifying Event within the 60-day period will disqualify the Qualified Person from continuation. Within 14 days following receipt of a notice of a Qualifying Event, The Principal will send the Qualified Person a Notification and Election form.

Name of Member		Member phone number	
Member address (street)	City	State	Zip code
Qualifying Event (reason coverage will terminate):			
Date of Qualifying Event:			
List all Qualified Persons (persons who will lose coverage and request continuation):			
Address that the Notification and Election form should be mailed to (if different than above):			
Qualified Person signature		Date	
Name of Group Policyholder		Account number	
Mail completed form to: Principal Life Insurance Company P. O. Box 4933 Grand Island, NE 68802-4933			

COBRA CONTINUATION

Federal Required Continuation - Consolidated Omnibus Budget Reconciliation Act (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) applies to any employer (except the federal government and religious organizations) that: (a) maintains group health coverage; and (b) normally employed 20 or more employees on a typical business day during the preceding Calendar Year. For this purpose, "employee" means full-time employees and full-time equivalent for part-time employees.

Where applicable, COBRA requires that your group health insurance allow qualified persons (described below) to continue group health coverage after it would normally end. The term "group health coverage" includes any medical, dental, vision care, and prescription drug coverages that are part of your insurance.

Note: COBRA Continuation is not available to state registered domestic partners or Domestic Partners or to a state registered domestic partner's or Domestic Partner's Dependent Child.

A. Qualified Persons/Qualifying Events

Continuation of group dental coverage must be offered to the following persons if they would otherwise lose that coverage as a result of the following qualifying events:

(1) a Member (and any covered Dependents) following the Member's:

(i) termination of employment for a reason other than gross misconduct; or

(ii) a reduction in work hours.

Reduction in work hours includes, but is not limited to, leave of absence, layoff, continuation due to sickness or injury, or when applicable, retirement.

(Note: Taking a family or medical leave under the Federal Family & Medical Leave Act (FMLA) is not a qualifying event under COBRA. A Member has a qualifying event when the Member does not return to work after the end of FMLA leave); and

(2) a Member's former spouse (and any Dependent Children) following a divorce or legal separation from the Member; and

(3) a Member's surviving spouse (and any Dependent Children), following the Member's death; and

(4) a Member's Dependent Child following loss of status as a Dependent under the terms of the Group Policy (e.g., attaining the maximum age, marriage, joining the Armed Forces, etc.); and

(5) a Member's spouse (and any Dependent Children) following the Member's entitlement to Medicare; and

(6) a Member's Dependent Child who is born to or placed for adoption with the Member who is on COBRA continuation due to termination of employment or reduction in work hours; and

(7) if the Group Policy covers retired Members, a retired Member and his/her Dependents (or surviving Dependents) when retiree dental benefits are "substantially eliminated" or terminated within one year before or after the employer files Chapter 11 (United States Code) bankruptcy proceedings.

B. Maximum Continuation Period

Following a qualifying event, dental coverage can continue up to the maximum continuation period. The maximum continuation period for a Member (and any Dependents) following a termination of employment or reduction in work hours is 18 months from the date of the qualifying event. The maximum continuation period for a Member's Dependent Child that is born to or placed for adoption with the Member while on COBRA continuation will extend to the end of the Member's maximum continuation period.

Following a termination of employment or reduction in work hours, a qualified person may request an 11-month extension of COBRA continuation. The maximum COBRA continuation will be 29 months from the date of the qualifying event (see Disabled Extension, Section D).

When a Member becomes entitled to Medicare before employment terminates or work hours are reduced, the maximum continuation period for the Dependents will be the longer of:

(1) 36 months dating back to the Member's entitlement to Medicare; or

(2) 18 months from the date of the qualifying event (termination of employment or reduction in work hours).

The maximum continuation period for qualified Dependents following a qualifying event described in A (2) through A (5) is 36 months from the date of the qualifying event.

If the Group Policy covers retired Members and the qualifying event is the employer's bankruptcy filing, the following rules apply:

(1) If the retired Member is alive on the date of the qualifying event, the retired Member and his or her spouse and Dependent Children may continue coverage for the life of the retired Member. In addition, if the retired Member dies while covered under COBRA, the spouse or Dependent Children may continue coverage for an additional 36 months.

(2) If the retired Member is not alive on the date of the qualifying event, his or her spouse may continue coverage to the date of his or her death.

C. Second Qualifying Events

If during an 18-month continuation period (or, 29 months for qualified persons on the disabled extension), a second qualifying event described in A (2) through A (5) occurs, the maximum continuation period may be extended for the qualified Dependents up to 36 months. That is, following a second qualifying event, qualified Dependents may continue for up to a maximum of 36 months dating from the Member's termination of employment or reduction in work hours. The extension is only available if the second qualifying event described in A (2) through A (5), absent the first qualifying event, would result in a loss of coverage for Dependents under the Group Policy. A Member's Dependent Child who is born to or placed for adoption with the Member who is on COBRA continuation may also be eligible for a second qualifying event that occurred prior to birth or placement for adoption.

D. Disabled Extension

Following a termination of employment or reduction in work hours, a qualified person (Member or Dependent) who has been determined disabled by the Social Security Administration either before or within 60 days after the qualifying event may request an extension of the continued coverage from 18 months to 29 months. A Member's Dependent Child who is born to or placed for adoption with the Member who is on COBRA continuation must be determined disabled by the Social Security Administration within 60 days after the date of birth or placement for adoption. The disabled extension also applies to each qualified person (the disabled person and any family members) who is not disabled and who is on COBRA continuation as a result of termination of employment or reduction in work hours.

The 11-month extension for all qualified persons will end the earlier of (a) 30 days following the date the disabled person is no longer determined by Social Security to be disabled, or (b) the date continuation would normally end as outlined in Section E below.

E. Termination of Continued Coverage

Continued coverage ends the earliest of the following:

(1) the date the maximum continuation period ends; or

(2) the date the qualified person enrolls in Medicare; however, this does not apply to a person who is already enrolled in Medicare on the date he or she elects COBRA or to a person who is on COBRA due to the employer's bankruptcy filing as described in A (7); or

(3) the end of the last coverage period for which payment was made if payment is not made prior to the expiration of the grace period. (See Grace Period, Section I.); or

(4) the date the Group Policy is terminated (and not replaced by another group dental plan); or

(5) the date the qualified person becomes covered by and has satisfied the preexisting exclusion provision of another group dental plan; however, this does not apply to a person who is already covered by the other group dental plan on the date he or she elects COBRA.

Note: Persons who, after the date of COBRA continuation election, become entitled to Medicare or become covered under another group dental plan and have satisfied the preexisting exclusion provision, are not eligible for continued coverage. However, if the Group Policy covers retired Members, continued coverage for retired persons and their Dependents (or surviving Dependents) due to qualifying event A (7) above may not be terminated due to Medicare coverage.

F. Employer/Plan Administrator Notification Requirement

When a Member or Dependent has a qualifying event due to termination of employment, reduction in work hours, death of the Member, the Member's entitlement to Medicare, or if the Group Policy covers retired Members, the commencement of the employer's Chapter 11 (United States Code) bankruptcy proceedings, the employer must notify the plan administrator within 30 days of the date of the qualifying event. The plan administrator must notify the qualified person of the right to COBRA continuation within 14 days after receiving notice of a qualifying event from the employer.

G. Qualified Person Notice and Election Requirement

Qualified persons must notify the plan administrator within 60 days after (a) the date of a qualifying event (i.e., divorce, legal separation, or a child ceases to be a Dependent Child under the terms of the Group Policy); (b) the date the qualified person would otherwise lose coverage as a result of a qualifying event; or (c) the date the qualified person is first informed of this notice obligation; otherwise the right to COBRA continuation ends. This 60-day notice period applies to initial and second qualifying events.

Qualified persons who request an extension of COBRA due to disability must submit a Written request to the plan administrator before the 18-month COBRA continuation period ends and within 60 days after the latest of the following dates: (a) the date of disability determination by the Social Security Administration; (b) the date of the qualifying event; (c) the date the qualified person would otherwise lose coverage as a result of a qualifying event; or (d) the date the qualified person is first informed of this notice obligation; otherwise the right to the disabled extension ends. Qualified persons must also notify the plan administrator within 30 days after the date the Social Security Administration determines the qualified person is no longer disabled.

Notification of a qualifying event to the plan administrator must be in Writing and must include the following information: (a) name and identification number of the Member and each qualified beneficiary; (b) type and date of initial or second qualifying event; (c) if the notice is for an extension due to disability, a copy of any letters from the Social Security Administration and the Notice of Determination; and (d) the name, address and daytime phone number of the qualified person (or legal representative) that the plan administrator may contact if additional information is needed to determine COBRA rights.

Within 14 days after receiving notice of a qualified event from the qualified person, the plan administrator must provide the qualified person with an election notice.

Qualified persons must make Written election within 60 days after the later of: (a) the date group health coverage would normally end; or (b) the date of the plan administrator's election notice. The election notice must be returned to the plan administrator within this 60-day period; otherwise the right to elect COBRA continuation ends.

Each qualified person has an independent right to elect COBRA. A covered Member may elect COBRA continuation on behalf of his/her covered spouse. A covered Member, parent, or legal guardian may elect COBRA continuation on behalf of his/her covered Dependent Children.

To protect COBRA rights, the plan administrator must be informed of any address changes for covered Members and Dependents. Retain copies of any notices sent to the plan administrator.

H. Monthly Cost

Persons electing continued coverage can be required to pay 102% of the cost for the applicable coverage (COBRA permits the inclusion of a 2% billing fee). Persons who qualify for the disabled extension and are not part of the family unit that includes the disabled person can be required to continue to pay 102% of the cost for the applicable coverage during the disability extension. Persons who qualify for the disabled extension and are part of the family unit that includes the disabled person can be required to pay 148% of the cost for the applicable coverage (plus a 2% billing fee) for the 19th through the 29th month of coverage (or through the 36th month if a second qualifying event occurs during the disabled extension).

I. Grace Period

Qualified persons have 45 days after the initial election to remit the first payment. The first payment must include all payments due when sent. All other payments (except for the first payment) will be timely if made within the Grace Period. "Grace Period" means the first 60-day period following a premium due date. Except for the first payment, a Grace Period of 60 days will be allowed for payment of premium. Continued coverage will remain in effect during the Grace Period provided payment is made prior to the expiration of the Grace Period. If payment is not made prior to the expiration of the Grace Period, continued coverage will terminate at the end of the last coverage period for which payment was made.

J. Policy Changes

Continued coverage will be subject to the same benefits and rate changes as the Group Policy.

K. Newly Acquired Dependents

A qualified person may elect coverage for a Dependent acquired during COBRA continuation. All enrollment and notification requirements that apply to Dependents of active Members apply to Dependents acquired by qualified persons during COBRA continuation.

Coverage for a newly acquired Dependent will end on the same dates as described for qualified persons in Section B above. Exception: Coverage for newly acquired Dependents, other than the Member's Dependent Child who is born to or placed for adoption with the Member, will not be extended as a result of a second qualifying event.

L. Contact Information

To notify the plan administrator of an initial or second qualifying event, request a disabled extension, request termination of COBRA, change of address, or request additional information concerning the Group Policy or COBRA, contact the following:

Group Dental Plan:	SAN LEANDRO BOYS & GIRLS Dental Plan
Contact Name/Area:	SAN LEANDRO BOYS & GIRLS Benefits Department
Address:	401 MARINA BLVD SAN LEANDRO CA 94577
Phone Number:	510-483-5581

NOTE: Under some circumstances, insurance under the Group Policy may be extended beyond the maximum COBRA continuation period. See "State Required Continuation - California" on the "Continuation of Coverage" page in this booklet.

FEDERAL FAMILY AND MEDICAL LEAVE ACT (FMLA)

Continuation

Federal law requires that Eligible Employees be provided a continuation period in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA).

This is a general summary of the FMLA and how it affects the Group Policy. See your employer for details on this continuation provision.

FMLA and Other Continuation Provisions

If your employer is an Eligible Employer and if the continuation portion of the FMLA applies to your insurance, these FMLA continuation provisions:

- are in addition to any other continuation provisions of the Group Policy, if any; and
- will run concurrently with any other continuation provisions of the Group Policy for sickness, injury, layoff, or approved leave of absence, if any.

If continuation qualifies for both state and FMLA continuation, the continuation period will be counted concurrently toward satisfaction of the continuation period under both the state and FMLA continuation periods.

Eligible Employer

Eligible Employer means any employer who is engaged in commerce or in any industry or activity affecting commerce who employs 50 or more employees for each working day during each of 20 or more calendar workweeks in the current or preceding Calendar Year.

Eligible Employee

Eligible Employee means an employee who has worked for the Eligible Employer:

- for at least 12 months; and
- for at least 1,250 hours during the year preceding the start of the leave; and
- at a worksite where the Eligible Employer employs at least 50 employees within a 75-mile radius.

For this purpose, "employs" has the meaning provided by the Federal Family and Medical Leave Act (FMLA).

Mandated Unpaid Leave

Eligible Employers are required to allow 12 workweeks of unpaid leave during any 12-month period to Eligible Employees for one or more of the following reasons:

- the birth of a child of an Eligible Employee and in order to care for the child;
- the placement of a child with the Eligible Employee for adoption or foster care;
- to care (physical or psychological care) for the spouse, child, or parent of the Eligible Employee, if they have a "serious health condition";

- a "serious health condition" that makes the Eligible Employee unable to perform the functions of his or her job; or

- because of a "qualifying exigency" arising out of a spouse, son, daughter or parent on active duty to a foreign country or having been notified of a call to active duty.

Eligible Employers are required to allow up to a total of 26 workweeks of unpaid leave during any 12-month period to eligible employees to care for a "covered military member" with a "serious injury or illness". Covered military member means a current member of the Armed Forces and the National Guard or Reserves. It also includes a covered veteran who was a member of the Armed Forces (including a member of the National Guard or Reserves), and was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date an employee takes FMLA leave.

Eligible Employers are required to allow 15 days of unpaid leave during any 12-month period to eligible employees to spend time with a military member on "rest and recuperation" leave.

Reinstatement

An Eligible Employee's terminated insurance may be reinstated in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA), subject to the Actively at Work requirements of the Group Policy.

See your employer for details on this reinstatement provision.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

Federal law requires that if your insurance would otherwise end because you enter into active military duty or inactive military duty for training, you may elect to continue insurance (including Dependents insurance) in accordance with the provisions of Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Continuation

If Active Work ends because you enter active military duty, insurance may be continued until the earliest of:

- for you and your Dependents:
    - the date the Group Policy is terminated; or
    - the end of the premium period for which premium is paid if you fail to make timely payment of a required premium; or
    - the date 24 months after the date you enter active military duty; or
    - the date after the day in which you fail to return to Active Work or apply for reemployment with the Policyholder.
- for your Dependents:
    - the date Dependent Dental Expense Insurance would otherwise cease as provided on GH 1104; or
    - the end of any Insurance Month desired, if requested by you before that date.

The continuation provision will be in addition to any other continuation provisions described in the Group Policy for sickness, injury, layoff, or approved leave of absence, if any. If you qualify for both state and USERRA continuation, the election of one means the rejection of the other.

Note: USERRA Continuation is not available to state registered domestic partners or Domestic Partners or to a state registered domestic partner's or Domestic Partner's Dependent Child.

Reinstatement

For Dental Expense Insurance, the reinstatement time period may be extended for an approved leave of absence taken in accordance with the provisions of the federal law regarding USERRA. The Actively at Work provision, described in the Group Policy, will not apply to the reinstated insurance.

This is a general summary of the USERRA and how it affects your Group Policy. See your employer for details on this continuation provision.

DESCRIPTION OF BENEFITS

DENTAL EXPENSE INSURANCE
(PAYMENT PROVISIONS)

Benefit Qualification

To qualify for payment of the benefits provided by your plan for an insured class, you and your Dependents must:

- be insured in that class on the date dental Treatment or Service is received; and
- satisfy the requirements listed in the CLAIM PROCEDURES Section.

Benefits Payable

Benefits payable will be as described in this section, subject to:

- all listed limitations; and
- the terms and conditions of COORDINATION WITH OTHER BENEFITS.

DENTAL EXPENSE INSURANCE

BENEFIT PROVISIONS

Payment Conditions

If you or one of your Dependents receive any Treatment or Service that is listed in the Schedule of Dental Procedures, We will pay Dental benefits for Covered Charges:

- in excess of the Deductible Amount(s); and
- at the payment percentage(s) indicated; and
- to the Maximum Payment Limits;

as described in the SUMMARY OF BENEFITS Section.

Covered Charges

Covered Charges will be the actual cost charged to you or your Dependent for Treatment or Service for the listed procedures shown in the SCHEDULE OF DENTAL PROCEDURES Section but only to the extent that the actual cost charged does not exceed Prevailing Charges. Also:

- if more than one procedure could be performed to correct a dental condition, Covered Charges will be limited to the Prevailing Charge for the least expensive of the procedures that would provide professionally acceptable results; and
- Covered Charges will include only those charges for Treatment or Service that begin (see below) while you and your Dependents are insured under the Group Policy; and
- Covered Charges will include only those charges for Treatment or Service that is completed while you and your Dependents are insured under the Group Policy (except when the Treatment or Service is covered under the Extended Benefits provision).

Beginning Date for Treatment or Service

Treatment or service will be considered to begin:

- for root canal therapy, on the date the pulp chamber is opened, and the pulp canal explored to the apex; and
- for crowns, fixed bridgework, inlays or onlay restoration, on the date the tooth or teeth are fully prepared; and
- for complete or partial dentures, on the date the master impression is made; and
- for all other, on the date the Treatment or Service is performed.

Completion Date for Treatment or Service

Treatment or Service will be considered to be completed:

- for root canal therapy, on the date the tooth is sealed; and

- for crowns, on the date the crown is seated; and
- for fixed bridgework, on the date the bridge is seated; and
- for inlay or onlay restorations, on the date the inlay or onlay is seated; and
- for complete or partial dentures, on the date the complete or partial denture is seated.

DENTAL EXPENSE INSURANCE - LIMITATIONS

Limitations

Covered Charges will not include and no benefits will be paid for:

- Treatment or Service that is not a Covered Charge; or
- the services of any person who is not a Dentist or Dental Hygienist; or
- any part of a charge for Treatment or Service that exceeds Prevailing Charges; or
- the services of any person who is in an insured person's Immediate Family; or
- implants; or
- Treatment or Service that does not meet professionally recognized standards of quality; or
- veneers, anterior 3/4 cast crowns, personalization of dentures or crowns (or any other Treatment or Service that is primarily cosmetic); or
- drugs, medicines, or therapeutic drug injections when not billed as part of a listed Covered Charge under Dental Care Units 1, 2, and 3 ; or
- instructions for plaque control, oral hygiene, or diet or nutritional counseling when billed as a separate Treatment or Service from examinations; or
- bite registration or occlusal analysis; or
- Treatment or Service to alter or maintain vertical dimension or restore or maintain occlusion; or
- Treatment or Service to duplicate or replace a lost or stolen prosthetic device or to duplicate or replace a lost or stolen appliance; or
- Orthodontic Treatment or Service; or
- Treatment or Service for provisional or permanent splinting; or
- Treatment or Service for which you or your Dependent have no financial liability or that would be provided at no charge or at a different charge in the absence of insurance; or
- Treatment or Service that is temporary; or
- Treatment or Service that is paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law); or
- Treatment or Service that results from a sickness that is paid under a Workers' Compensation Act or other similar law; or
- Treatment or Service that results from an injury arising from or in the course of any employment for wage or profit; except this limitation will not apply to: partners, proprietors, or corporate officers of the employer who are not covered by a Workers' Compensation Act or other similar law; or

- Treatment or Service that results from war or act of war; or
- Treatment or Service that results from commission of or attempted commission of a felony or voluntary participation in an illegal occupation; or
- Treatment or Service provided outside the United States, unless you or your Dependent are outside the United States for one of the following reasons:
    - travel, provided the travel is for a reason other than securing dental care diagnosis or treatment; or
    - a business assignment, provided you or your Dependent are temporarily outside the United States; or
    - full-time student status, provided the student is either:
        - enrolled and attending an accredited school in a foreign country; or
        - is participating in an academic program in a foreign country, for which the institution of higher learning at which the student is enrolled in the U.S. grants academic credit; or
- Treatment or Service replacing tooth structure lost from abrasion, attrition, erosion, or abfraction; or
- Treatment or Service which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three years; or
- Treatment or Service that is an Experimental or Investigational Measure. (The denial of any claim on the basis of the exclusion of coverage for experimental or investigational Treatment or Service may be appealed through the procedure described in the notice of that claim decision); or
- Treatment or Service that is paid by a Medicare Supplement Insurance Plan; or
- Treatment or Service for temporomandibular joint disorders; or
- charges by an anesthesiologist for services that were performed in facilities other than a dental office; or
- emergency room charges or outpatient facility charges (including but not limited to hospital outpatient facility charges); or
- Treatment or Service for patient management (including but not limited to nitrous oxide and analgesia), local anesthetic and general anesthesia and IV sedation, except as otherwise provided in the Group Policy; or
- Occlusal guards; or
- charges that are billed incorrectly or separately for Treatment or Services that are an integral part of another billed Treatment or Service.

SCHEDULE OF DENTAL PROCEDURES - UNIT 1

Unless We agree otherwise, Covered Charges will include only charges for procedures listed in this section. If a non-listed procedure is accepted, We will determine its maximum allowance based on the Prevailing Charges for a listed procedure of comparable nature.

Dental Care Unit 1 - Preventive Procedures

Subject to the terms and conditions described under Payment Conditions on GH 1107, Covered Charges will be the actual cost charged to you or your Dependent for Treatment or Service for the listed procedures described in this section but only to the extent that the actual cost charged does not exceed Prevailing Charges.

Dental Procedure

Examinations

Only two of the below listed procedures will be covered in any Calendar Year.

Oral examination (evaluation)

Periodic examination (evaluation)

Emergency examination (evaluation)

Office visit

Second Opinion

Benefits will be payable for a Second Opinion obtained with respect to a recommended Treatment or Service at 100% of Second Opinion Consultation Charges, subject to Prevailing Charges.

Note: Obtaining a confirming Second Opinion does not guarantee payment of the Treatment or Service. All other terms, provisions, conditions, limitations, and exclusions of the Group Policy remain in full force and effect with respect to benefits.

Radiographs

Full Mouth Survey

Complete series (including bitewings)
Panoramic

Only one of the listed full mouth surveys will be covered in any 60 consecutive month period.

Bitewing

Only one set will be covered in any Calendar Year.

Occlusal

Only two films will be covered in any Calendar Year.

Periapical

Only four films will be covered in any Calendar Year.

Extraoral X-Rays

Sialography
Cephalometric film
Posterior-anterior or lateral skull and facial bone survey

Only two of the listed extraoral procedures will be covered in any 12 consecutive month period.

Diagnostic x-rays performed in conjunction with root canal therapy or orthodontic treatment will not be considered Unit 1 Covered Charges.

Preventive Services

Prophylaxis (cleaning of teeth)

Limited to two dental prophylaxis in any Calendar Year. Prophylaxis includes both routine cleaning and periodontal cleaning/maintenance procedures. The periodontal prophylaxis is paid under Unit 2. However, the service applies to the two prophylaxis limit.

Topical application of fluoride

Applicable only to Dependent Children under the age of 14. Only one application(s) will be covered in any Calendar Year.

Topical application of sealants

Applicable only to first and second permanent molars for Dependent Children under age 14. Covered once each tooth in any 36 consecutive month period.

SCHEDULE OF DENTAL PROCEDURES - UNIT 2

Unless We agree otherwise, Covered Charges will include only charges for procedures listed in this section. If a non-listed procedure is accepted, We will determine its maximum allowance based on the Prevailing Charges for a listed procedure of comparable nature.

Dental Care Unit 2 - Basic Procedures

Subject to the terms and conditions described under Payment Conditions on GH 1107, Covered Charges will be the actual cost charged to you or your Dependent for Treatment or Service for the listed procedures described in this section but only to the extent that the actual cost charged does not exceed Prevailing Charges.

Dental Procedure

Restorations

Fillings (amalgam or resin-based composite)

Anterior

Mesial-lingual, distal-lingual, mesial-buccal, and distal buccal restoration will be considered single surface restorations.

Multiple restorations on adjacent surfaces of the same tooth are considered connected. Benefits will be based on the benefit for a single restoration reflecting the number of different surfaces.

Multiple restorations on the same surface of the same tooth will be based on the benefit for a single surface restoration.

Posterior

Multiple restorations on adjacent surfaces of the same tooth are considered connected. Benefits will be based on the benefit for a single restoration reflecting the number of different surfaces.

Multiple restorations on the same surface of the same tooth will be based on the benefit for a single surface restoration.

Replacement

Replacement of existing fillings are covered only if at least 24 consecutive months have passed since placement of prior fillings, unless required by new decay in an additional tooth surface.

Benefits for composite restorations on posterior teeth will be based on the benefits for the corresponding amalgam restorations.

Stainless Steel Crown
Prefabricated Resin Crown

> For Dependent Children under the age of 19, only one of the listed crowns will be covered in any 24 consecutive month period. If a stainless steel or Prefabricated Resin Crown is used for an adult in lieu of a permanent crown, all replacement restrictions will be as listed for permanent crowns on GH 1111. If a permanent crown replaces a crown listed in this section at a later date but before replacement restrictions allow, all new charges will be reduced by those already paid.

Endodontic Services

Vital pulpotomy

Covered for deciduous teeth only.

Root canal therapy including treatment plan, intraoperative x-rays, clinical procedures, and follow-up care. Retreatment of previous root canal therapy covered once per tooth per lifetime.

Apexification
Apicoectomy - Covered once per root per lifetime
Retrograde filling - Covered once per root per lifetime
Root amputation
Root resection
Hemisection

Periodontic Services

Scaling and root planing (each quadrant)

Covered once each quadrant in any 24 consecutive month period.

Note: If you or your Dependent are pregnant, diabetic or has heart disease, scaling and root planing will be paid at 100% and one additional routine cleaning or periodontal cleaning will be allowed.

Full Mouth Debridement

Covered once per lifetime. Only covered if no other service (other than x-rays) is provided during the visit.

Periodontal Prophylaxis (includes probing, charting, polishing, scaling, root planing, and similar maintenance procedures).

Covered only if at least three months have elapsed after completion of covered active therapeutic scaling and root planing or covered active surgical periodontal treatment. Limited to two dental prophylaxis (routine cleaning or periodontal cleaning/maintenance procedure) in any Calendar Year.

Prophylaxis includes both routine cleaning and periodontal cleaning/maintenance procedures. The routine prophylaxis is paid under Unit 1. However, the service applies to the two prophylaxis limit.

Periodontal Surgical Procedures

Gingival flap procedure
Gingivectomy
Osseous surgery
Pedicle soft tissue graft
Free soft tissue graft
Subepithelial connective tissue graft
Distal or proximal wedge procedure
Crown lengthening

Only one of the listed periodontic surgical procedures is covered for each quadrant in any 36 consecutive month period.

Bone Replacement Graft

Covered once per site per lifetime.

Oral Surgery

Simple extraction
Surgical removal of erupted tooth
Root removal - exposed roots

There will be no separate benefit payable for bone grafting of an extraction site.

Incision and drainage of dental abscess
Biopsy of soft tissue

Other Oral Surgical Procedures

Extraction of impacted teeth (soft tissue, partial bony, complete bony)
Surgical root removal

There will be no separate benefit payable for bone grafting of an extraction site.

Alveoplasty
Removal of exostosis
Removal of palatal torus
Removal of mandibular tori
Frenectomy
Transseptal fiberotomy
Excision of hyperplastic tissue
Surgical exposure of impacted or unerupted tooth
Vestibuloplasty
Removal of dental cysts and tumors

Anesthesia

General anesthesia
IV sedation

General anesthesia or IV sedation is payable for the following covered services when performed in a dental office. Benefits for anesthesia is limited to one hour unless complexity of service warrants extended time.

Removal of impacted teeth, removal of dental cysts and tumors, multiple restorative services for Dependent Children under the age of five, periodontal osseous surgery, bone grafting, surgical removal of four third molars on the same date of service.

Other Services

Consultation with specialist

Covered once in any 12 consecutive month period. Covered as a separate procedure only if no other service (except x-rays) is provided during the visit.

Antibiotic drug injection

Office visit after regularly scheduled hours

Covered as a separate procedure only if no other service (except x-rays) is provided during the visit.

Palliative treatment

Covered as a separate procedure only if no other service (except x-rays) is provided during the visit.

Harmful Habit Appliance

Limited to one time per person under age 14.

Space Maintainers

Applicable only to Dependent Children under age 14. Repairs to space maintainers are not covered. Limited to one bilateral space maintainer per arch or one unilateral space maintainer per quadrant.

SCHEDULE OF DENTAL PROCEDURES - UNIT 3

Unless We agree otherwise, Covered Charges will include only charges for procedures listed in this section. If a non-listed procedure is accepted, We will determine its maximum allowance based on the Prevailing Charges for a listed procedure of comparable nature.

Dental Care Unit 3 - Major Procedures

Subject to the terms and conditions described under Payment Conditions on GH 1107, Covered Charges will be the actual cost charged to you or your Dependent for Treatment or Service for the listed procedures described in this section but only to the extent that the actual cost charged does not exceed Prevailing Charges.

Dental Procedure

Restorations

Inlays and onlays

Inlay or onlay restorations are covered only if the tooth cannot be restored by a filling and (for replacements) at least 120 consecutive months have elapsed since the last placement.

For persons under 16 years of age, the benefit for inlay is limited to amalgam or resin filling.

For persons under 16 years of age, the benefit for onlay is limited to resin or stainless steel crowns.

The date the inlay or onlay is cemented in the mouth will be used in determining benefits payable.

Crowns (single restorations only)

Resin (laboratory)
Resin with nonprecious metal
Resin with semiprecious metal
Resin with gold
Porcelain
Porcelain with nonprecious metal
Porcelain with semiprecious metal
Porcelain with gold
Porcelain (3/4 posterior cast)
Gold (3/4 posterior cast)
Gold (full cast)
Nonprecious metal (full cast)
Semiprecious metal (full cast)

Crowns are covered only if the tooth cannot be restored by a filling and (for replacements) at least 120 consecutive months have elapsed since the last placement. Crowns for the primary purpose of splinting, altering, or maintaining vertical dimension, or restoring occlusion are not covered. Crowns for the replacement of inlay or onlay or bridge abutment are covered only if at least 120 consecutive months have elapsed since the last placement of the restoration. Crowning of implant replacing a tooth missing prior to the effective date is not covered. For persons under 16 years of age, the benefit for crown on vital teeth is limited to prefabricated resin or stainless steel crowns. Crowning of implant replacing a pontic will not be covered unless at least 120 consecutive months have elapsed since placement of the pontic. The date the crown is cemented in the mouth will be used in determining benefits payable.

Cast post and core

Covered only for teeth that have had root canal therapy. Covered once per tooth per 120 consecutive months. There will be no separate benefit payable for cast post and core if restorative procedure is not covered under this plan.

Core Buildup

Covered only when required for retention and preservation of the tooth. There will be no separate benefit payable for core buildup if restorative procedure is not covered under this plan.

Covered once per tooth per 120 consecutive month period.

Prosthodontics, Fixed

Fixed bridges - initial placement or replacement

Coverage for bridges limited to persons over age 16.

Initial placement of fixed bridges to replace teeth which were missing prior to the effective date of the insured person's coverage will not be covered unless it includes the replacement of a Performing Natural Tooth extracted while the person is insured under the Group Policy (provided that tooth was not an abutment to an existing partial denture that is less than 60 months old). In that event, benefits are payable only for the replacement of those teeth which were extracted while insured under the Group Policy.

Benefits for the replacement of an existing fixed bridge are payable only if the existing bridge is more than 120 consecutive months old and is not serviceable and cannot be repaired.

The date bridgework is cemented in the mouth will be used in determining benefits payable.

Prosthodontics, Removable

Complete or partial dentures - initial placement or replacement

Initial placement of complete or partial dentures to replace teeth which were missing prior to the effective date of the insured person's coverage will not be covered unless it includes the replacement of a Performing Natural Tooth extracted while insured under the Group Policy. In that event, benefits are payable only for the replacement of those teeth which were extracted while insured under the Group Policy.

Benefits for the replacement of an existing complete or partial denture are payable only if the existing denture is more than 60 consecutive months old and is not serviceable and cannot be repaired.

Covered Charges for complete or partial dentures do not include any additional charges for over-dentures or for precision or semi-precision attachments.

Other Services

Recementing

Inlay
Onlay
Crown
Bridgework

Covered only if done more than 12 months after initial insertion of inlay, onlay, crown, or bridge, and then not more than one time in any 24 consecutive month period.

Repairs to complete or partial denture, bridge, or crown

Covered only if repair is done more than 12 months after initial insertion of the denture, bridge, or crown, and then not more than one time in any 24 consecutive month period.

Relining or rebasing complete or partial dentures

Covered only if relining or rebasing is done more than 12 months after initial insertion of the denture and then not more than one time in any 24 consecutive month period.

Tissue Conditioning

Covered only if at least 12 months have elapsed since the insertion of a complete or partial denture and not more than once in any 24 consecutive month period.

Denture Adjustment

Covered once in any 12 consecutive month period and only if at least 12 months have elapsed since the insertion of the denture.

DENTAL EXPENSE INSURANCE

EXTENDED BENEFITS (after termination of insurance)

If Dental Expense Insurance under the Group Policy ceases and if you or your Dependents qualify, We will pay for:

- root canal therapy, but only if the pulp chamber was opened and the pulp canal explored to the apex while you or a Dependent were insured under the Group Policy; and
- crowns, bridges, inlays, or onlay restorations, but only if the tooth or teeth were fully prepared while you or a Dependent were insured under the Group Policy; and
- complete or partial dentures, but only if the master impression was made while you or a Dependent were insured under the Group Policy;

provided the Treatment or Service is received within 30 days after your insurance or a Dependent's insurance terminates.

You or a Dependent will qualify if:

- you or a Dependent would have qualified for benefit payment under the Group Policy had insurance remained in force; and
- the Treatment or Service began while you or a Dependent were insured under the Group Policy; and
- the Group Policy is in force at the time Treatment or Service is received.

However, no extended benefits will be paid for Treatment or Service received on or after the date you or your Dependents become eligible for other group dental expense coverage, unless Written documentation is provided that Treatment or Service began while you or your Dependent were insured under the Group Policy and the proceeding carrier will not provide coverage for the completed Treatment or Service.

DENTAL EXPENSE INSURANCE

COORDINATION WITH OTHER BENEFITS

Applicability

These Coordination of Other Benefits (COB) provisions apply to this Plan when you or one of your Dependents have dental care insurance under more than one Plan. "Plan" is defined below.

If the COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this Plan are determined before or after those of another plan. The benefits of this Plan:

- will not be reduced when, under the order of benefit determination rules, this Plan determines its benefits before another plan; but
- may be reduced when, under the order of benefits determination rules, another plan determines its benefits first.

Benefits paid under all other Plans plus the sum of benefits paid under the Group Policy will not exceed the lesser of the financial liability of the Member or Dependent or Our Prevailing Charge for a Treatment or Service.

Definitions

*"Plan" is any of these which provides benefits or services for, or because of, medical or dental care or treatment provided under:

- any insured or noninsured group, service, prepayment, or other program arranged through an employer, trustee, union, or association; and
- any program required or established by state or Federal law (including Medicare Parts A and B); and
- any program sponsored by or arranged through a school or other educational agency.

The term Plan will not include benefits provided under:

- a student accident policy; or
- a state medical assistance program where eligibility is based on financial need; or
- individual or family policies; or
- individual or family subscriber contracts; or
- entitlements to Medi-Cal benefits; or
- benefits provided under the California Crippled Children Services program; or
- the medical payment benefits customarily included in the traditional automobile contracts; or
- any other coverage provided for or required by law when its benefits are excess to any private insurance or other non-governmental program.

*In the event a husband and wife or a Member and his or her registered domestic partner are both employed by the Policyholder, each Plan will be considered a separate Plan with respect to those coordination of benefits provisions. The amount payable will not be more than 100% of the actual cost charged for Treatment or Service.

"Primary Plan/Secondary Plan." The order of benefit determination rules determine whether this Plan is a "Primary Plan" or a "Secondary Plan" when compared to another Plan covering the person.

When this Plan is Primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits. When this Plan is Secondary, its benefits are determined after those of another Plan and may be reduced because of the Primary Plan's benefits.

"Allowable Expense." A dental care service or expense, including Deductibles, coinsurance, and Copayments, if any, that is covered at least in part by any of the Plans covering the person for whom benefits are claimed. When a Plan provides benefits in the form of services (for example a DHMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses.

- If a person is covered by two or more Plans that compute their benefits payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.

- The amount a benefit is reduced by the Primary Plan because a covered person does not comply with the Plan provisions. Example of this provision is preferred provider arrangements.

"Claim Determination Period" means the part of a Calendar Year during which you or a Dependent would receive benefit payments under this Plan if this section were not in force.

Effect on Benefits

Benefits otherwise payable under this Plan for Allowable Expenses during a Claim Determination Period may be reduced if:

- benefits are payable under any other Plan for the same Allowable Expenses; and

- the rules listed below provide that benefits payable under the other Plan are to be determined before the benefits payable under this Plan.

The reduction will be the amount needed to provide that the sum of payments under this Plan plus benefits payable under the other Plan(s) is not more than the total of Allowable Expenses.

For this purpose:

- benefits payable under other Plans will include the benefits that would have been paid had claim been made for them;

- for any person covered by Medicare Part A, benefits payable will include benefits provided by Medicare Part B whether or not the person is covered under that Part B.

Order of Benefit Determination

General. Except as described below under Medicare Exception, the benefits payable of a Plan that does not have a coordination of benefits provision similar to the provision described in this section will be determined before the benefits payable of a Plan that does have such a provision. In all other instances, the order of determination will be:

Rules. This Plan determines its order of benefits using the first of the following rules which applies:

- Nondependent/Dependent. The Plan which covers the person as an employee, Member, or subscriber (that is, other than a Dependent) are determined before those of the Plan which covers the person as a Dependent. Exception: If the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

  - secondary to the Plan covering the person as a Dependent; and

  - primary to the Plan covering the person as other than a Dependent (e.g., a retired employee), then the benefits of the Plan covering the person as a Dependent are determined before those of the Plan covering that person as other than a Dependent.

- Dependent Child--Parents Not Separated or Divorced. If a Dependent Child is covered by both parents' Plans, the Plan of the parent whose birthday falls earlier in the Calendar Year will be determined before those of the Plan of the parent whose birthday falls later in that year. But, if both parents have the same birthday or if the other Plan does not have a birthday rule, and as a result the Plans do not agree on the order of benefits, the benefits of the Plan which covered a parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

  However, if the other Plan does not have the rule described above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

- Dependent Child--Separated or Divorced Parents. If a Dependent Child of legally separated or divorced parents is covered under two or more Plans, benefits for the Dependent Child are determined in this order:

  - first, the Plan of the parent with custody of the Dependent Child;

  - then, the Plan of the spouse or registered domestic partner of the parent with custody of the Dependent Child; and

  - finally, the Plan of the parent not having custody of the Dependent Child.

  However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the Dependent Child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply for any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the Dependent Child, the Plans covering the Dependent Child shall follow the order of benefit determination rules for Dependent Children of parents who are not separated or divorced.

- Active/Inactive Employee. The benefits of a Plan which covers a person as an employee who is neither laid-off nor retired are determined before those of a Plan which covers that person as a laid-off or retired employee. The same would hold true if a person is a Dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

- Continuation of Coverage. If a person for whom coverage is provided under a right of continuation according to Federal or state law is also covered under another Plan, the following will be the order of benefit determination:

  - first, the benefits of a Plan covering the person as an employee, Member, or subscriber (or as that person's Dependent);

- second, the benefits under the continuation coverage.

  If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

- Longer/Shorter Length of Coverage. If none of the above rules determine the order of benefits, the benefits of the Plan which covered an employee, Member, or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

Medicare Exception

Unless otherwise required by Federal law, benefits payable under Medicare will be determined before the benefits payable under the Group Policy.

Federal law will usually apply in such instances if:

- the benefits are applicable to an active (rather than a retired) Member or to that Member's spouse; and

- the Member's employer has 20 or more employees.

How COB Works

Example 1: The natural father is insured as a Member under this Plan. Company A covers the natural mother. Company B covers the stepfather. The natural mother has custody of the Dependent Child and the divorce decree does not establish financial responsibility for medical, dental, or other health care expenses.

The following order of benefits would apply to the Dependent Child:

1. Company A would be Primary (mother's carrier).

2. Company B would be Secondary (stepfather's carrier).

3. We would then determine the benefits payable, if any, under this Plan.

Example 2A: Mrs. Smith has filed a claim for $600 with both Company A and Company B. Company A insures Mrs. Smith as an employee under a plan which pays 80% of Covered Charges after a $50 Calendar Year deductible is satisfied. Company B insures her as a dependent spouse under a plan.

Both plans have a COB provision, therefore, Company A would pay first since it insures Mrs. Smith as an employee. Since Company A pays first, it calculates benefits in full as though duplicate coverage did not exist.

Company A

Billed Charges	$	600	
Not Covered By Primary Carrier	$	- 20	(oral hygiene instructions)
Total Covered Charges	$	580	
Less Deductible	$	- 50	
Benefits Payable ($530 x 80% = $424)	$	424	

Once Company A has determined and paid its benefits, Mrs. Smith's claim is then considered by Company B. In calculating its benefit, Company B must include any expenses that would be allowable expenses under the Company A plan.

Company B

Allowable Expenses	$	580
Less Company A Benefits	$	-424
Benefits Payable	$	156

The Patient is responsible for $20 which is not considered a covered expense under either policy.

Example 2B: The same rules apply in this example as they did in Example 2A. Mrs. Smith has filed an additional claim for $800 with both Company A and Company B. Company A insures Mrs. Smith as an employee under a plan which pays 80% of Covered Charges after a $50 Calendar Year deductible is satisfied. Company B insures her as a dependent spouse under a plan.

Both plans have a COB provision, therefore, Company A would pay first since it insures Mrs. Smith as an employee. Since Company A pays first, it calculates benefits according to their plans Covered Charges as though duplicate coverage did not exist.

Company A

Billed Charges	$	800	
Not Covered By Primary Carrier	$	- 20	(oral hygiene instructions)
Total Covered Charges	$	780	
Less Deductible	$	- 50	
Benefits Payable ($730 x 80% = $584)	$	584	

Once Company A has determined and paid its benefits, Mrs. Smith's claim is then considered by Company B.
In calculating its benefit, Company B must include any expenses that would be allowable expenses under the Company A plan.

Company B

Allowable Expenses	$	780
Less Company A Benefits	$	-584
Benefits Payable By Company B	$	196

The Patient is responsible for $20 which is not considered a covered expense under either policy.

CLAIM PROCEDURES

Notice of Claim

We will acknowledge verbal or Written notice of claim within 15 calendar days of receipt unless payment is made within that time period.

Claim Forms

Except in the case of dental care received from PPO or EPO Providers, when We receive notice of claim, We will provide claim forms, instructions, and reasonable assistance within 15 calendar days of receipt of such notice.

Proof of Loss

Completed claim forms and other information needed to prove loss should be filed promptly. Written proof of loss should be sent to Us 12 months after the date of loss. For purposes of satisfying the claim processing requirements, receipt of claim will be considered to be met when We receive proof of loss. Proof of loss includes the patient's name, your name (if different from patient's name), provider of services, dates of service, diagnosis, description of Treatment or Service provided and extent of the loss. We may request additional information to substantiate your loss or require a Signed unaltered authorization to obtain that information from the provider. Your failure to comply with such request could result in declination of the claim. We may also require x-rays, dental charts, and other evidence needed to determine the dental condition treated and the services provided.

Payment, Denial, and Review

The Employee Retirement Income Security Act (ERISA) permits up to 30 calendar days from receipt of claim for processing the claim. If a claim cannot be processed due to incomplete information, We will send a Written explanation prior to the expiration of the 30 calendar days. If we do not deny the claim and request additional information to complete the review, the claimant is then allowed up to 45 calendar days to provide all additional information requested. We will render a decision within 15 calendar days of either receiving the necessary information or upon the expiration of 45 calendar days if no additional information is received.

In actual practice, benefits under the Group Policy may be payable sooner, provided We receive complete and proper proof of loss. If a claim is not payable or cannot be processed, We will submit a detailed explanation of the basis for its denial.

A claimant may request an appeal of a claim denial by Written request to Us within 180 calendar days of receipt of the notice of denial. We will make a full and fair review of the claim. We may require additional information to make the review. We will notify the claimant in Writing of the appeal decision within 60 calendar days of receiving the appeal request. The appeal review must be completed before filing a civil action or pursuing any other legal remedies.

For purposes of this section, "claimant" means you or your Dependent.

State law permits up to 30 days after receipt of proof of claim to determine if the claim will be paid or denied. If a determination cannot be made within 30 days, We will send a Written explanation describing the information necessary to establish receipt of claim prior to the end of the original 30 days and every 30 days thereafter, (Exception: If there is a reasonable basis for Us to believe a claim is false or fraudulent, the limit is extended to 80 days).

If it is determined that the claim will be paid, payment must be made within 30 days of (a) determination of coverage, or (b) execution of a settlement agreement.

If the claim is denied, in whole or in part, We will notify the claimant in Writing of the basis for the denial. This denial notice will include an explanation of the policy provision, condition, or exclusion relevant to the facts of the claim. The notice will also provide the address and telephone number of the unit of the California Department of Insurance the claimant should contact for review if he or she believes the claim has been wrongfully denied.

Preferred and Exclusive Providers

When you become insured, you will be issued an identification card. This card should be presented to each PPO Provider at the time you or a Dependent receive needed dental care. Each PPO Provider will provide you with a claim form and other filing assistance.

Dental Treatment Plan

We encourage the use of predeterminations to determine the extent of coverage for a proposed course of treatment. A Dental Treatment Plan may be filed with Us before treatment begins. Upon receipt of the Dental Treatment Plan, We will provide a Written response indicating the benefits that may be payable for the proposed treatment. We suggest predetermination of benefits for the following non-emergency types of treatments: inlays, onlays, single crowns, prosthetics, periodontics and oral surgery.

The filing of a Dental Treatment Plan is intended to help avoid any misunderstanding between you, the Dentist and Us as to how much will be paid for dental work. A Dental Treatment Plan is not a guarantee of what We will pay. It informs you and the Dentist, in advance, what We will pay for a covered dental service named in the Dental Treatment Plan. If We do not agree with a Dental Treatment Plan, We have the right to base payments on treatment suited to your condition by accepted standards of dental practice.

Facility of Payment

We will normally pay all benefits to you. However, if the claimed benefits result from a Dependent's dental care, We may make payment to the Dependent. Also, in the special instances listed below, payment will be as indicated. All payments so made will discharge Us to the full extent of those payments.

- If payment amounts remain due upon your death, those amounts may be paid to your estate, spouse, state registered domestic partner, Domestic Partner, child, or parent, or a provider of dental services.

- If We believe a person is not legally able to give a valid receipt for a benefit payment, and no guardian has been appointed, We may pay whoever has assumed the care and support of the person.

- Benefits payable to a PPO Provider will be paid directly to the PPO Provider on behalf of you or your Dependent.

Note: When benefits under the Group Policy are payable for Treatment or Services received from a foreign provider, the claim must be filed in English and requested in American currency amounts. Such claims will be payable for Covered Charges for Treatment or Services but only to the extent that the actual cost charged does not exceed Prevailing Charges. Benefits will be paid directly to the Member. No assignments will be made to foreign providers.

Recoding of Procedures

When a claim contains one or more procedure codes with the same date of service, We may review the claim to determine whether it contains, among other things, coding irregularities (including duplicative or combined codes), coding conflicts or coding errors. We will base such review on generally recognized and authoritative coding resources, including but not limited to: Current Dental Terminology (CDT).

If We determine that the claim may be more appropriately coded using the same or different codes, the claim will be recoded and processed accordingly to determine the allowable amount and extent of benefits.

Dental Examinations

We may have the person whose loss is the basis for dental claim examined by a Dentist. We will pay for these examinations and will choose the Dentist to perform them.

Legal Action

Legal action for a claim may not be started earlier than 90 calendar days after proof of loss is filed and before the appeal procedures have been exhausted. Further, no legal action may be started later than three years after proof is required to be filed.

Time Limits

All time limits listed in this section will be adjusted as required by law.

STATEMENT OF RIGHTS

Federal law requires that this section be included in your booklet:

As a participant in this plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- 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 Pension and Welfare Benefit Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and 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.

- 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.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan or the rules governing your COBRA continuation coverage rights.

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 your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other 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.

Enforce 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.

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 Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, 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 state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in 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 have 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 your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any 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 Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.

SUPPLEMENT TO YOUR BOOKLET-CERTIFICATE

The Employee Retirement Income Security Act (ERISA) requires that certain information be furnished to each participant in an employee benefit plan. Policyholders may use this booklet-certificate in part in meeting Summary Plan Description requirements under ERISA.

1. **Employer Plan Identification Number:**

   EIN: 94-6003779

2. **Type of Administration:**

   Dental Insurance Contract.

3. **Plan Administrator:**

   SAN LEANDRO BOYS & GIRLS CLUB
   401 MARINA BLVD
   SAN LEANDRO CA 94577

   See your employer for the business telephone number of the Plan Administrator.

4. **Plan Sponsor:**

   SAN LEANDRO BOYS & GIRLS CLUB
   401 MARINA BLVD
   SAN LEANDRO CA 94577

5. **Agent for Service of Legal Process:**

   SAN LEANDRO BOYS & GIRLS CLUB
   401 MARINA BLVD
   SAN LEANDRO CA 94577
   (510)483-5581

   Legal process may also be served upon the plan administrator.

6. **Type of Participants Insured Under the Plan:**

   All active full-time employees of SAN LEANDRO BOYS & GIRLS CLUB, and provided that, for each employee, he or she also meets the definition of a Member as defined in the DEFINITIONS Section of this booklet (page GH 1117).

7. **Sources and Methods of Premium Payments to the Plan:**

   Members are required to contribute a portion of the premium for their insurance under the Group Policy.

   Members are required to contribute all of the premium for their Dependent's insurance under the Group Policy (if Member elects to enroll Dependents in plan).

8. **Ending Date of Plan's Fiscal Year:**

November 30

DEFINITIONS

Several words and phrases used to describe your plan are capitalized whenever they are used in this booklet. These words and phrases have special meanings as explained in this section.

Accidental Injury means an injury to the natural teeth that is caused by accident. Not included is any injury that results from chewing.

Active Work; Actively at Work means the active performance of all of your normal job duties at the Policyholder's usual place or places of business.

Calendar Year means January 1 through December 31 of each year.

Covered Charges means a Treatment or Service is considered to be a Covered Charge if the Treatment or Service is prescribed by a Dentist and is:

- necessary and appropriate;
- Generally Accepted.

Deductible; Deductible Amount mean a specified dollar amount of Covered Charges that must be incurred by the insured person before benefits will be payable under the Group Policy for all or part of the remaining Covered Charges during the Calendar Year.

Dental Charges Database (DCD) means a dental charge information database at provided by FAIR Health, Inc. which provides historical information about the charges of dental care providers by procedure code and geographic cost areas.

The Dental Charges Database will be updated by Us as information becomes available from the database supplier, up to twice each year. When there is minimal data available from the DCD for a Treatment or Service, We will modify the database to reflect our own experience. If database continues to have minimal data for the actual Treatment or Service performed, We will determine the Prevailing Charge by calculating the cost for an applicable alternative Treatment or Service using the DCD and multiplying value difference of the applicable alternate Treatment or Service to the actual Treatment or Service performed.

> **IMPORTANT:** If you or one of your Dependents choose to receive dental Treatment or Service that is not a Covered Charge under the Group Policy, the provider may charge you or one of your Dependents his or her usual and customary rate for the dental Treatment or Service. Before providing the non covered dental Treatment or Service, the provider should provide you or one of your Dependents with a Dental Treatment Plan that includes each anticipated dental Treatment or Service and the estimated cost of each service. If you would like more information about dental coverage options, you may call member services at the number shown on your ID card.

Dental Hygienist means a person who works under the supervision of a Dentist and is licensed to practice dental hygiene.

Dental Treatment Plan means the Dentist's report of proposed treatment which:

- is in Writing; and
- lists the procedures required for the Period of Dental Treatment; and
- shows the charges for each procedure; and
- is accompanied by diagnostic materials.

Dentist means:

- a person licensed to practice dentistry; and
- a licensed Physician who provides dental Treatment or Service.

Dependent means:

- your spouse or state registered domestic partner, if your spouse or state registered domestic partner is not in the Armed Forces of any country.
- your Dependent Child (or Children) as defined below; and
- your Domestic Partner, if you and the Domestic Partner complete and submit a Declaration of Domestic Partnership which is approved by Us.

Dependent Child; Dependent Children means:

- Your natural child, if that child:
  - is not insured under the Group Policy as a Member; and
  - is less than 26 years of age.
- Your stepchild, if that child:
  - meets the requirements above; and
  - receives principal support from you.
- Your foster child, if that child:
  - meets the requirements above; and
  - lives with you; and
  - receives principal support from you; and
  - is under legal guardianship of you or your spouse or Domestic Partner; and
  - is approved in Writing by Us as a Dependent Child.
- Your adopted child, if that child meets the requirements above and you:
  - are a party in a lawsuit in which you are seeking the adoption of the child; or
  - have custody of the child under a court order that grants custody of the child to you.

  An adopted child will be considered a Dependent Child on the earlier of: the date the petition for adoption is filed; or the date of entry of an order granting the adoptive parent custody of the child for the purpose of adoption.
- Your state registered domestic partner's child who otherwise qualifies above or if you or your state registered domestic partner is the child's guardian by court order.

- Your Domestic Partner's child who otherwise qualifies above or if you or your Domestic Partner is the child's guardian by court order.

Dependent Child will include any child covered under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) as defined by applicable federal law and state insurance laws that are applicable to the Group Policy, provided the child meets the Group Policy's definition of a Dependent Child.

Developmental Disability means a Dependent Child's substantial handicap, which:

- results from mental retardation, cerebral palsy, epilepsy, or other neurological disorder; and
- is diagnosed by a Physician as a permanent or long term continuing condition.

Domestic Partner (other than state registered domestic partners) means your opposite sex or same sex life partner, provided:

- your partner is not in the Armed Forces of any country; and
- your partner is at least 18 years of age; and
- neither your partner nor you are married; and
- neither your partner nor you have had another Domestic Partner in the six-month period preceding the date of the Signed Declaration of Domestic Partnership; and
- your partner is not your blood relative; and
- your partner and you have shared the same residence for at least six consecutive months and continue to do so; and
- your partner and you are each other's sole life partner and intend to remain so indefinitely; and
- your partner and you are jointly responsible for each other's financial welfare; and
- your partner and you are not in the relationship solely for the purpose of obtaining insurance coverage.

Emergency Treatment means any Treatment or Service, which is rendered as the direct result of an unforeseen occurrence or combination of circumstances which requires immediate, urgent action or remedy.

Exclusive Provider; EPO Provider means a Dentist contracted within the Exclusive Provider Organization (EPO) network established by the EPO identified on your ID card.

Except in the case of Emergency Treatment, the insured person must seek needed dental care from a participating Dentist in order to obtain benefits. The Policyholder's participation in an EPO network does not mean that the insured person's choice of provider will be restricted. The insured person may seek needed dental care from any Dentist of his or her choice. However, in order to avoid higher charges and reduced benefit payment, the insured persons are urged to obtain such care from Exclusive Providers whenever possible.

We have the right to terminate the Exclusive Provider Organization (EPO) portion of the Group Policy if We or the Exclusive Provider Organization (EPO) terminates the arrangement. In the event of termination, persons insured under the EPO Plan, as described in the Group Policy, will automatically be transferred to an alternative plan of benefits as agreed upon between the Policyholder and Us.

We also have the right to identify different Exclusive Provider Organizations from time to time and to terminate the designation of any Exclusive Provider at any time. In the event of termination, The Principal will pay for Treatment or Service, as described in this Group Policy, for persons insured under the EPO plan, who are under the care of such Exclusive Provider at the time of termination until such Treatment or Service is completed, unless reasonable and medically appropriate arrangements or assumption of such Treatment or Service by another Exclusive Provider is made.

EPO Service Area means the geographic area within which Exclusive Provider services are available to persons insured under the Group Policy. For the purposes of the Group Policy, the EPO Service Area includes the following California counties: Los Angeles, Orange, Ventura, Imperial, Riverside, San Bernardino, San Diego, Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, San Luis Obispo, Santa Barbara, Butte, El Dorado, Fresno, Kern, Kings, Madera, Merced, Monterey, Placer, Sacramento, San Joaquin, Sonoma, Stanislaus and Tulare.

Experimental or Investigational Measures means any Treatment or Service, regardless of any claimed therapeutic value, not Generally Accepted by a specialist in that particular field of dentistry.

Full-Time Employee means any person, residing in the United States, who is a U.S. citizen or is legally working in the United States, who is regularly scheduled to work for the Policyholder for at least 30 hours a week. You must be compensated by the Policyholder and either the employer or employee must be able to show taxable income on federal or state tax forms. Work must be at the Policyholder's usual place or places of business or at another place to which an employee must travel to perform his or her regular duties. A person is considered to be residing in the United States if his or her main home or permanent address is in the United States or if the person is in the United States for six months or more during any 12-month period.

An owner, proprietor, or partner of the Policyholder's business will be deemed to be an eligible employee for purposes of the Group Policy, provided he or she is regularly scheduled to work for the Policyholder for at least 30 hours a week and otherwise meets the definition of Full-Time Employee.

Generally Accepted means Treatment or Service which is the subject of the claim that:

- has been accepted as the standard of practice according to the prevailing opinion among experts as shown by (or in) articles published in authoritative, peer-reviewed dental and scientific literature; and
- is in general use in the relevant dental community; and
- is not under scientific testing or research.

Group Policy means the policy of group insurance issued to the Policyholder by Us which describes benefits and provisions for insured Members and Dependents.

Harmful Habit Appliances means appliances, either fixed or removable, used to train or remind a patient to avoid thumb sucking or tongue thrusting (does not include treatment for bruxism - clenching or grinding of the teeth).

Immediate Family means an insured person's spouse, state registered domestic partner, Domestic Partner, natural or adoptive parent, natural or adoptive child, sibling, stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild or spouse of grandparent or grandchild.

Insurance Month means calendar month.

Lapse in Coverage means any break in coverage during which a person is not covered under another group dental expense coverage, including but not limited to any Policyholder benefit waiting period. Continuation provided under COBRA or any state required continuation will not be considered a break in coverage.

Member means any PERSON who is a Full-Time Employee of the Policyholder.

Natural Tooth means any tooth or part of a tooth that is organic and formed by the natural development of the body (i.e. not manufactured).

Non-Exclusive Provider; Non-EPO Provider means a Dentist who has not contracted with the Exclusive Provider Organization (EPO) network established by the EPO identified on your ID card.

Non-Preferred Provider/Non-PPO Provider means a Dentist not contracted with the Dental Preferred Provider Organization (PPO) network established by the PPO identified on your ID card.

Orthodontic Treatment or Service means any Treatment or Service for:

- straightening of teeth, formal, full-banded retention and treatment, including x-rays and other diagnostic procedures; and

- removable or fixed appliances for tooth or bony structure guidance or retention.

Performing Natural Tooth means a Natural Tooth which is serving its normal role in the chewing process in the insured person's upper or lower arch and which is opposed in the person's other arch by another Natural Tooth or prosthetic (i.e., artificial) replacement.

Period of Dental Treatment means all sessions of dental care that result from the same initial diagnosis and any related complications.

Physical Handicap means a Dependent Child's substantial physical or mental impairment which:

- results from injury, accident, congenital defect, or sickness; and

- is diagnosed by a Physician as a permanent or long-term dysfunction or malformation of the body.

Physician means a licensed Doctor of Medicine (M.D.) or Osteopathy (D.O.).

Placement for Adoption; Placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adopting the child. The child's placement with the person terminates upon the termination of such legal obligation.

Point-of-Service (POS) Plan means a managed approach to providing dental care that allows the insured person to decide how he/she wants to receive care each time he/she needs dental care. The insured person can choose to receive dental care through a network of providers or from any provider of his/her choice. When the insured person uses an in-network provider, he/she pays less for Treatment or Services than he/she would when using an out-of-network provider.

Policyholder means SAN LEANDRO BOYS & GIRLS CLUB.

Preferred Provider/PPO Provider means a Dentist contracted within the Dental Preferred Provider Organization (PPO) network established by the PPO identified on your ID Card.

The Policyholder participation in a PPO network does not mean that the insured person's choice of provider will be restricted. The insured person may seek needed dental care from any Dentist of his or her choice. However, in order to avoid higher charges and reduced benefit payment, the insured persons are urged to obtain such care from Preferred Providers whenever possible.

We have the right to terminate the Preferred Provider Organization (PPO) portion of the Group Policy if We or the Preferred Provider Organization (PPO) terminates the arrangement.

We also have the right to identify different preferred provider organizations from time to time, and to terminate the designation of any Preferred Provider at any time.

Preferred Provider Organization (PPO) means the PPO identified on your ID card.

Prevailing Charges means:

- For dental care received from Exclusive Providers or Preferred Providers, the negotiated fee between the Exclusive Providers and the EPO or between the Preferred Provider and the PPO.

- For dental care received from Non-Exclusive Providers/Non-Preferred Providers, the amount that most dental care providers charge within a geographic cost area for a Treatment or Service.

The geographic cost area will be determined by the first three digits of a zip code.

For purposes of the coverage provided under the Group Policy, the actual cost charged for a Treatment or Service will be in excess of Prevailing Charges, but only to the extent that the actual cost charged exceeds the 90th percentile identified on the Dental Charges Database (DCD). Non-Exclusive Providers/Non-Preferred Providers may charge you or your Dependent the difference between the actual cost charged and the Prevailing Charge.

Second Opinion means an opportunity to obtain a clinical evaluation by a provider other than the provider originally making a recommendation for a proposed Treatment or Service to assess the clinical necessity and appropriateness of the proposed service.

Second Opinion Consultation Charges means Covered Charges for:

- consultation with a Second Opinion Physician to obtain a Second Opinion prior to a Treatment or Service for which a Second Opinion is recommended; and

- necessary diagnostic, x-ray or laboratory examinations performed in connection with such consultation.

Second Opinion Physician means a Physician or Dentist who is:

- an appropriate specialist for the particular Treatment or Service recommended; and

- not a partner or associate of the Physician or Dentist who recommended or will perform the Treatment or Service.

Signed or Signature means any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper or electronic media, and which is consistent with applicable law and is agreed to by Us.

Treatment or Service, when used in this booklet, will be considered to mean "treatment, service, substance, material, or device".

We, Us, and Our means Principal Life Insurance Company, Des Moines, Iowa.

Written or Writing means a record which is on or transmitted by paper or electronic media, and which is consistent with applicable law.

BOOKLET-CERTIFICATE NOTICE

California insurance law requires that a group policy include the telephone number of the insurance company issuing the policy in order for the persons to present inquiries, to obtain information about coverage, and to provide assistance in resolving complaints. Persons may call or write to:

Principal Life Insurance Company
711 High Street
Des Moines, Iowa 50392-0002

Dental claim-related inquiries:
Attn: Group Claim - Dental Info Line Services
Phone: 1-800-247-4695

For administration-related inquiries:
Attn: Group Call Center
Phone: 1-800-843-1371

Consumers should contact Principal Life Insurance Company, their agent or other representative regarding complaints. If the policy or certificate was issued or delivered by an agent or broker, the insured must contact his or her agent or broker for assistance.

The California Department of Insurance should be contacted only after discussions with the insurer, or its agent or other representative, or both have failed to produce a satisfactory resolution to the problem.

Persons may contact:

California Insurance Department
Health Claims Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
Phone: 1-800-927-4357 (HELP)
TDD: 1-800-482-4833
Website: www.insurance.ca.gov

This Notice is for your information only and does not become a part or condition of this booklet-certificate.

BOOKLET-CERTIFICATE NOTICE
TIMELY ACCESS TO CARE

The state of California wants you to know you have the right to expect the following from your Preferred Provider:

- Urgent appointments must be offered within 72 hours of the time of request for an appointment, when consistent with your needs and as required by professionally recognized standards of practice;
- Non-urgent appointments must be offered within 36 business days of the request for an appointment; and
- Preventive appointments must be offered within 40 business days of the request for an appointment.

The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, has determined and noted in the record that a longer waiting time will not have a detrimental impact on your health.

When it is necessary for you or your Preferred Provider to reschedule an appointment, the appointment must be promptly rescheduled in a manner that is appropriate for your health care needs, and ensures continuity of care consistent with good professional practice.

At the time of your appointment, you can get an interpreter. For help, call us at the number listed on your ID card or 1-800-247-4695. For more help, persons may contact:

California Insurance Department
Health Claims Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
Phone: 1-800-927-4357 (HELP)
TDD: 1-800-482-4833
Website: www.insurance.ca.gov

If you have a complaint about timely access to care in regard to your Preferred Provider, you may file a complaint with the California Insurance Department or with Us using the addresses or phone numbers provided on GH 198 CA in this booklet-certificate.

This notice is for your information only and does not become a part or condition of this booklet-certificate.

BOOKLET-CERTIFICATE NOTICE
CONFIDENTIAL COMMUNICATIONS REQUEST

The state of California wants you to know you have the right to make a request to receive communications of confidential health care information from us by alternative means or at an alternative location.

To make this request, you must complete, sign, and submit a "Confidential Communications Request" form. This form, along with directions on how to complete and return it to us, can be found on our website at: https://www.principal.com/help/help-individuals/find-form under "Restrict access to Private Health Information".

If you need assistance locating the request form, you may contact us at 1-800-843-1371.

This notice is for your information only and does not become a part or condition of this booklet-certificate.

California Language Assistance Notice

Principal Life Insurance Company
Des Moines, IA 50392-0002

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. Written translations are available in Spanish only. For help, call us at the number listed on your ID card or 1-800-247-4695. For more help call the CA Dept. of Insurance at 1-800-927-4357.

Servicios de idiomas sin costo. Solicite un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-800-247-4695. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-800-247-4695. للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357. Arabic

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-800-247-4695 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

免費語言服務。您可獲得口譯員服務，用中文把文件唸給您聽。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打 1-800-247-4695 與我們聯絡。欲取得其他協助，請致電1-800-927-4357 與加州保險部聯絡。Chinese

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-800-247-4695 . Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

मुफ़्त भाषा सेवा. आपको दुभाषिया की सेवा मिल सकती है. दुभाषिए आपको दस्तावेज़ पढ़वा कर सुना सकते हैं और कुछ आपको आपकी भाषा में दस्तावेज़ भेज देते हैं. लिखित अनुवाद सिर्फ़ स्पेनिश में उपलब्ध हैं. सहायता के लिए, अपने आई कार्ड पर दिए गए नंबर या 1-800-247-4695 पर कॉल करें. अधिक सहायता के लिए, 1-800-927-4357 पर CA डिपार्टमेंट ऑफ़ इंश्योरेंस से बात करें. Hindi

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または 1-800-247-4695 までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Japanese

សេវាកម្មភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-800-247-4695 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

ບໍ່ມີຄ່າບໍລິການດ້ານພາສາ ທ່ານຈະມີນາຍແປພາສາໃຫ້. ທ່ານສາມາດເອົາເອກະສານເຜື່ອມາຢ່ານເອງ ແລະ ບາງສ່ວນແມ່ນສົ່ງໃຫ້ທ່ານໂດຍປັ້ນພາສາຂອງທ່ານ.
ການແປພາສາທີ່ເປັນລາຍລັກອັກສອນນັ້ນ ຈະມີແຕ່ພາສາເອັດສະປາຍເທົ່ານັ້ນ.
ສໍາລັບຄວາມຊ່ວຍເຫຼືອ, ໂທຫາພວກເຮົາຕາມລາຍການເບີໂທ ທີ່ຢູ່ໃນ ID ຂອງທ່ານ ຫຼື 1-800-247-4695. ສໍາລັບຂໍ້ຄວາມຊ່ວຍເຫຼືອເພີ່ມເຕີມ ໃຫ້ໂທຫາພະແນກ CA ຂອງປະກັນໄພ ທີ່ເບີ 1-800-927-4357. Lao

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-800-247-4695 번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

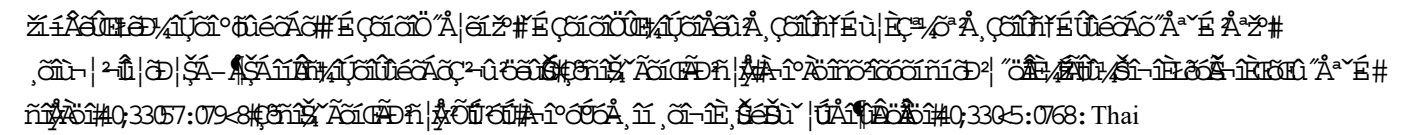
Tengx nzie weih faan waac bun muangx se maiv zuqc feix zinh nyaanh. Meih haih lorx longc mienh liouh tengx faan waac. Meih corc haih zipv benx sou-nzangc liouh dorh mingh doqc mangc aengx caux maaih deix yaac duqv faan benx meih nyei fingz waac. Dungh fiev benx sou-nzangc faan daaih nyei waac se kungx zoux benx janx Spanish nduqc fingz waac hnangv oc. Liouh lorx mienh tengx nzie naaiv diuc jauv-louc nor, douc waac daaih lorx taux yie mbuo gan gu'ndiev norm finx-gorn dungh fiev hietv meih nyei ID fangx-daan wuov a'fai 1-800-247-4695. Aengx zoiz qiemx longc tengx jaa camv faaux nyei jauv-louc nor douc waac lorx taux CA gunv goux beu weih sou-gorn domh gorn zangc yiem njiec naaiv 1-800-927-4357. Mien

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 1-800-247-4695 تماس بگیرید. برای دریافت کمک بیشتر، به (اداره بیمه کالیفرنیا) CA Dept. of Insurance به شماره 1-800-927-4357 تلفن کنید. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-800-247-4695 'ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-800-247-4695 . Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-800-247-4695 . Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog



Безплатні послуги з перекладу. Ви можете скористатися послугами усного перекладача. Вам прочитають, а в деяких випадках і надішлють документи вашою мовою. Письмовий переклад наявний лише для іспанської мови. За довідкою телефонуйте за номером, вказаним на вашій ідентифікаційній картці, або 1-800-247-4695. За додатковою інформацією телефонуйте до Департаменту страхування в Каліфорнії за номером 1-800-927-4357. Ukrainian

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch và được người khác đọc giúp các tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-800-247-4695 . Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese.

California Nondiscrimination Notice

Principal Life Insurance Company
Des Moines, IA 50392-0002

Discrimination is against the law. Principal Life Insurance Company (Principal Life) follows State and Federal civil rights laws. Principal Life does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation in connection with the group dental and vision care insurance benefits provided to customers.

No Cost Language Services

Principal Life provides access to no cost language services for people whose primary language is not English. You can get an interpreter. You can get documents read to you and some sent to you in your language. Written translations are available in Spanish only.

Relay Services for the hearing impaired

Principal Life is approved to assist customers using any Federal Communications Commission (FCC) approved relay service provider. Relay services include Video Relay Service (VRS) which allows the hearing impaired to place and receive calls with a professional American Sign Language (ASL) interpreter via a videophone and a high-speed internet connection. VRS and videophone calls are free to the hearing impaired.

A list of FCC approved relay service providers can be accessed at: https://www.fcc.gov/general/internet-based-trs-providers.

If you need these services, contact Principal Life between 7:30 am and 6:00 pm (CST) by calling the number on your ID card or 1-800-247-4695.

HOW TO FILE A GRIEVANCE

If you believe that Principal Life has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance with Principal Life's Office of the General Counsel. You can file a grievance by phone, in writing, or electronically at:

Principal Life Insurance Company
Office of the General Counsel
711 High Street
Des Moines, IA 50392-0300
Phone: 515-247-6498
E-mail: CSDClaims@exchange.principal.com

CALIFORNIA DEPARTMENT OF INSURANCE

You can also file a civil rights complaint with the California Department of Insurance by phone, in writing, or electronically:

- By phone: Call **1-800-927-4357**. If you cannot speak or hear well, please call **TDD 1-800-482-4833.**

- In writing: Fill out a complaint form or send a letter to:
  California Department of Insurance
  Consumer Services and Market Conduct Branch
  Consumer Services Division
  300 South Spring Street, South Tower
  Los Angeles, CA 90013

  Complaint forms are available at:
  http://www.insurance.ca.gov/01-consumers/101-help/

  Electronically: Visit the Getting Help page at http://www.insurance.ca.gov/01-consumers/101-help/

OFFICE OF CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.

- In writing: Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services 200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

- Electronically: Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Notice of Privacy Practices for Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes the practices of Principal Life Insurance Company for safeguarding individually identifiable health information. The terms of this Notice apply to members, their spouses and dependents for their group dental expense, group vision care expense, group hospital indemnity, and/or group critical illness insurance with us ("insurance"). As used in this Notice, the term "health information" means information about you that we create, receive or maintain in connection with your insurance; that relates to your physical or mental condition or payment for health care provided to you; and that can reasonably be used to identify you. This Notice was effective April 14, 2003 and revisions to this Notice are effective August 1, 2022.

We are required by law to maintain the privacy of our members' and dependents' health information and to provide notice of our legal duties and privacy practices with respect to their health information. We are required to abide by the terms of this Notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make the new Notice effective for all health information maintained by us. Copies of revised Notices will be mailed to plan sponsors for distribution to the members then covered by our insurance. You have the right to request a paper copy of the Notice, although you may have originally requested a copy of the Notice electronically by e-mail.

Uses and Disclosures of Your Health Information

Authorization. Except as explained below, we will not use or disclose your health information for any purpose unless you have signed a form authorizing a use or disclosure. Unless we have taken any action in reliance on the authorization, you have the right to revoke an authorization if the request for revocation is in writing and sent to: Compliance Privacy Consultant, Specialty Benefits Division (SBD) Compliance, Principal Life Insurance Company, Des Moines, IA 50392-0002. Once we receive your request, a form to revoke an authorization will be sent to your attention for completion.

Disclosures for Treatment. We may disclose your health information as necessary for your treatment. For instance, a doctor or healthcare facility involved in your care may request your health information in our possession to assist in your care.

Uses and Disclosures for Payment. We will use and disclose your health information as necessary for payment purposes. For instance, we may use your health information to process or pay claims, for subrogation, to provide a pre-determination of benefits or to perform prospective reviews. We may also forward information to another insurer in order for it to process or pay claims on your behalf. Unless we agree in writing to do otherwise, we will send all mail regarding a member's spouse or dependents to the member, including information about the payment or denial of insurance claims.

Uses and Disclosures for Health Care Operations. We will use and disclose your health information as necessary for health care operations. For instance, we may use or disclose your health information for quality assessment and quality improvement, credentialing health care providers, premium rating, conducting or arranging for medical review or compliance. We may also disclose your health information to another insurer, health care facility or health care provider for activities such as quality assurance or case management. We participate in an organized health care arrangement with the health plan of a member's employer. We may disclose your health information to your health plan for certain functions of its health care operations. This Privacy Notice does not cover the privacy practices of that plan. We may contact your health care providers concerning prescription drug or treatment alternatives.

Other Health-Related Uses and Disclosures. We may contact you to provide reminders for appointments; information about treatment alternatives; or other health-related programs, products or services that may be available to you.

Information Received Pre-enrollment. We may request and receive from you and your health care providers health information prior to your enrollment under the insurance. We will use this information to determine whether you are eligible to enroll under the insurance and to determine the rates. We will not use or disclose any genetic information we obtain about you or provided from your family history. If you do not enroll, we will not use or disclose the information we obtained about you for any other purpose. Information provided on enrollment forms or applications will be utilized for all coverages being applied for, some of which may be protected by the state, not federal, privacy laws.

Business Associate. Certain aspects and components of our services are performed by outside people or organizations pursuant to agreements or contracts. It may be necessary for us to disclose your health information to these outside people or organizations that perform services on our behalf. We require them to appropriately safeguard the privacy of your health information. Principal Life Insurance Company may itself be a business associate of your health plan or health insurance company. We may disclose your health information to your health plan or insurance company and its business associates as needed to fulfill our contractual obligations to them. Please see the notice of privacy practices issued by your plan or insurance company for information about how it uses and discloses your health information.

Plan Sponsor. We may disclose your health information to the plan sponsor the minimum necessary amount of your health information that it needs to perform administrative functions on behalf of the plan (if any), provided that the plan sponsor certifies that the information will be maintained in a confidential manner and will not be utilized or disclosed for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor.

Family, Friends and Personal Representatives. With your approval, we may disclose to family members, close personal friends, or another person you identify, your health information relevant to their involvement with your care or paying for your care. If you are unavailable, incapacitated or involved in an emergency situation, and we determine that a limited disclosure is in your best interests, we may disclose your health information without your approval. We may also disclose your health information to public or private entities to assist in disaster relief efforts.

Other Uses and Disclosures. We are permitted or required by law to use or disclose your health information, without your authorization, in the following circumstances:

- For any purpose required by law;
- For public health activities (for example, reporting of disease, injury, birth, death or suspicion of child abuse or neglect);
- To a governmental authority if we believe an individual is a victim of abuse, neglect or domestic violence;
- For health oversight activities (for example, audits, inspections, licensure actions or civil, administrative or criminal proceedings or actions);
- For judicial or administrative proceedings (for example, pursuant to a court order, subpoena or discovery request);
- For law enforcement purposes (for example, reporting wounds or injuries or for identifying or locating suspects, witnesses or missing people);
- To coroners and funeral directors;
- For procurement, banking or transplantation of organ, eye or tissue donations;
- For certain research purposes;
- To avert a serious threat to health or safety under certain circumstances;
- For military activities if you are a member of the armed forces; for intelligence or national security issues; or about an inmate or an individual to a correctional institution or law enforcement official having custody; and
- For compliance with workers' compensation programs.

We will adhere to all state and federal laws or regulations that provide additional privacy protections. We are prohibited from using or disclosing protected health information that is genetic information of an individual for purposes of determining eligibility for coverage, the amount of benefits or premiums or discounts, including rebates, payments in kind, or other premium or benefit differential mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program. We will not request, use or disclose psychotherapy notes without your authorization (except to defend ourselves in a legal action brought by you.) We will not sell your protected health

information or use or disclose it for marketing purposes without your authorization, except as permitted by law. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information.

Your Rights

Restrictions on Use and Disclosure of Your Health Information. You have the right to request restrictions on how we use or disclose your health information for treatment, payment or health care operations. You also have the right to request restrictions on disclosures to family members or others who are involved in your care or the paying of your care. We are not required to agree to your request for a restriction. If your request for a restriction is granted, you will receive a written acknowledgement from us.

Receiving Confidential Communications of Your Health Information. You have the right to request communications regarding your health information from us by alternative means (for example by fax) or at alternative locations. We will accommodate reasonable requests.

Access to Your Health Information. You have the right to inspect and/or obtain a copy of your health information we maintain in your designated record set, with a couple of exceptions. A fee will be charged for copying and postage.

Amendment of Your Health Information. You have the right to request an amendment to your health information to correct inaccuracies. We are not required to grant the request in certain circumstances.

Accounting of Disclosures of Your Health Information. You have the right to receive an accounting of certain disclosures of your health information made by us during the 6 year period before your request. The first accounting in any 12-month period will be free; however, a fee will be charged for any subsequent request for an accounting during that same time period.

Exercising your rights. To exercise any of the above rights, you must submit a written request indicating which rights you are requesting to: Compliance Privacy Consultant, Specialty Benefits Division (SBD) Compliance, Principal Life Insurance Company, 711 High Street, Des Moines IA 50392-0002. Once we receive your request, a form(s) will be sent to your attention for completion.

Complaints. If you believe your privacy rights have been violated, you can send a written complaint to us at Grievance Coordinator, Group Compliance, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0002 or to the Secretary of the U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

If you have any questions or need any assistance regarding this Notice or your privacy rights, you may contact the Group Call Center at Principal Life Insurance Company at (800) 843-1371.

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Principal Life Insurance Company
Des Moines, Iowa 50392-0002