1102845

01/01/2025

GROUP POLICY FOR:

UNIVERSITY OF CALIFORNIA POSTDOCTORAL SCHOLAR BENEFITS PLAN

ALL MEMBERS
Group Dental Point of Service (POS) Plan

Print Date: 10/31/2024

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CHANGE NO. --2-- AMENDMENT TO BE ATTACHED TO
AND MADE A PART OF
PRINCIPAL LIFE INSURANCE COMPANY GROUP
POLICY NO. GDE 1102845 ISSUED TO

UNIVERSITY OF CALIFORNIA POSTDOCTORAL SCHOLAR BENEFITS PLAN

It is agreed that the above Group Policy be amended effective as of January 1, 2025, by striking all pages and replacing such pages with the following updated Group Policy.

The effect of this change is to completely replace the documentation of the contract between the above-named Policyholder and The Principal. Therefore, as of the effective date of this change, all prior versions of that documentation are null and void. This change is not intended to renew the contract between the Policyholder and The Principal in any way which affects the time limits of the coverages or limitations as stated in the original documentation.

The provisions and conditions set forth on any attached page are part of this Amendment the same as if set forth above.

This Amendment will become effective as a Written agreement between The Principal and the Policyholder on the first premium due date following the effective date shown above for which premium due under this Group Policy is received by The Principal.

Executed by The Principal as of October 31, 2024.

Executive Vice President,
General Counsel and Secretary

Deanna D Strable-Soethout

President and
Chief Operating Officer

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PRINCIPAL LIFE INSURANCE COMPANY
(called The Principal in this Group Policy)
Des Moines, Iowa 50392-0002

This group insurance policy is issued to:

UNIVERSITY OF CALIFORNIA POSTDOCTORAL SCHOLAR BENEFITS PLAN

(called the Policyholder in this Group Policy)

The Date of Issue is January 1, 2019.

In return for the Policyholder's application and payment of all premiums when due, The Principal agrees to provide:

MEMBER AND DEPENDENT

GROUP DENTAL EXPENSE INSURANCE

POINT OF SERVICE (POS) PLAN

subject to the terms and conditions described in this Group Policy.

Executive Vice President,
General Counsel and Secretary

President and
Chief Operating Officer

GROUP POLICY NO. GDE 1102845
NONPARTICIPATING
CONTRACT STATE OF ISSUE: CALIFORNIA

This policy has been updated effective January 1, 2025

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PART I - DEFINITIONS

When used in this Group Policy, the terms listed below will mean:

Accidental Injury

An injury to the natural teeth that is caused by accident (excluding any injury that occurs from chewing).

Active Work; Actively At Work

The active performance of all of a Member's normal job duties at the Policyholder's usual place or places of business.

Calendar Year

January 1 through December 31 of each year.

Covered Charges

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

a. necessary and appropriate;

b. Generally Accepted.

Date of Issue

The date this Group Policy is placed in force: January 1, 2019.

Deductible; Deductible Amount

A specified dollar amount of Covered Charges that must be incurred by the Member or Dependent before benefits will be payable under this Group Policy for all or part of the remaining Covered Charges during the Calendar Year.

Dental Charges Database (DCD)

A dental charge information database provided by FAIR Health, Inc. which provides historical information about the charges of dental care providers by procedure code and geographic cost areas.

This policy has been updated effective January 1, 2025

The Dental Charges Database will be updated by The Principal 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, Principal will modify the database to reflect its own experience. If database continues to have minimal data for the actual Treatment or Service performed, Principal will determine the Prevailing Charge by calculating the cost for an applicable alternate Treatment or Service using the DCD and multiplying value difference of the applicable alternate Treatment or Service to the actual Treatment or Service performed.

Dental Health Maintenance Organization (DHMO)

An entity providing Dental coverage that is a lawful DHMO under applicable state or federal law and is identified by The Principal as alternative coverage to this Group Policy.

Dental Hygienist

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

Dental Treatment Plan

A Dentist's report of proposed dental treatment which:

a. is in Writing; and

b. lists the procedures required for the Period of Dental Treatment; and

c. shows the charges for each procedure; and

d. is accompanied by diagnostic materials.

Dentist

a. A person licensed to practice dentistry; and

b. a licensed Physician who provides dental Treatment or Service.

Dependent

a. A Member's spouse or state registered domestic partner, if that spouse or state registered domestic partner is not in the Armed Forces of any country.

b. A Member's Dependent Child (or Children) as defined below; and

This policy has been updated effective January 1, 2025

c. A Member's Domestic Partner, if the Member and the Domestic Partner complete and submit a Declaration of Domestic Partnership which is approved by The Principal.

Dependent Child; Dependent Children

a. A Member's natural child, if that child:

(1) is not insured under this Group Policy as a Member; and
(2) is less than 26 years of age.

b. A Member's stepchild, if that child:

(1) meets the requirements above; and
(2) receives principal support from the Member.

c. A Member's foster child, if that child:

(1) meets the requirements above; and
(2) lives with the Member; and
(3) receives principal support from the Member; and
(4) is under legal guardianship of the Member or Member's spouse or Domestic Partner; and
(5) is approved in Writing by The Principal as a Dependent Child.

d. A Member's adopted child, if that child meets the requirements above and the Member:

(1) is a party in a lawsuit in which the Member is seeking the adoption of the child; or
(2) has custody of the child under a court order that grants custody of the child to the Member.

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.

e. The Member's state registered domestic partner's child who otherwise qualifies above or if the Member or state registered domestic partner is the child's guardian by court order.

f. The Member's Domestic Partner's child who otherwise qualifies above or if the Member or 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

This policy has been updated effective January 1, 2025

and state insurance laws that are applicable to this Group Policy, provided the child meets this Group Policy's definition of a Dependent Child.

Developmental Disability

A Dependent Child's substantial handicap, which:

a. results from mental retardation, cerebral palsy, epilepsy, or other neurological disorder; and

b. is diagnosed by a Physician as a permanent or long term continuing condition.

Domestic Partner (other than state registered domestic partners)

A Member's opposite sex or same sex (other than state registered domestic partners), life partner, provided:

a. the partner is not in the Armed Forces of any country; and

b. the partner is at least 18 years of age; and

c. neither the partner nor the Member is married; and

d. neither the partner nor the Member has had another Domestic Partner in the six-month period preceding the date of the Signed Declaration of Domestic Partnership; and

e. the partner is not a blood relative of the Member; and

f. the partner and the Member have shared the same residence for at least six consecutive months and continue to do so; and

g. the partner and the Member are each other's sole life partner and intend to remain so indefinitely; and

h. the partner and the Member are jointly responsible for each other's financial welfare; and

i. the partner and the Member are not in their relationship solely for the purpose of obtaining insurance coverage.

Emergency Treatment

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.

This policy has been updated effective January 1, 2025

Exclusive Provider; EPO Provider

A Dentist contracted with an Exclusive Provider Organization (EPO) network identified by The Principal to this Group Policy.

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.

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

The Principal also has 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.

The Principal shall give the Policyholder 31 days advance notice in Writing of any termination or permanent breach of contract by, or permanent inability to perform of, any Exclusive Provider if such termination, breach or inability would materially and adversely affect the Policyholder or persons insured under the EPO plan, as described in this Group Policy. The Policyholder shall distribute the substance of such notice to persons insured under the EPO plan, as described in this Group Policy, within 30 days of receipt.

EPO Service Area

The geographic area within which Exclusive Provider services are available to persons insured under this Group Policy. For the purposes of this 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.

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Experimental or Investigational Measures

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

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 10 hours a week. The employee 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 in which an employee performs 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 this Group Policy, provided he or she is regularly scheduled to work for the Policyholder for at least 10 hours a week and otherwise meets the definition of Full-Time Employee.

Generally Accepted

Treatment or Service which is the subject of claim that:

a. 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

b. is in general use in the relevant dental community; and

c. is not under scientific testing or research.

Group Policy

The policy of group insurance issued to the Policyholder by The Principal which describes benefits and provisions for insured Members and Dependents.

Harmful Habit Appliances

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).

This policy has been updated effective January 1, 2025

Immediate Family

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

Calendar month.

Lapse in Coverage

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

Any PERSON who is a Full-Time Employee of the Policyholder.

Natural Tooth

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

A Dentist who has not contracted with the Exclusive Provider Organization (EPO) network identified by The Principal to this Group Policy.

Non-Preferred Provider/Non-PPO Provider

A Dentist not contracted with the Dental Preferred Provider Organization (PPO) network identified by The Principal to this Group Policy.

Orthodontic Treatment or Service

Any Treatment or Service for:

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

This policy has been updated effective January 1, 2025

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

Period of Dental Treatment

All sessions of dental care that result from the same initial diagnosis and any related complications.

Physical Handicap

A Dependent Child's substantial physical or mental impairment, which:

a. results from injury, accident, congenital defect, or sickness; and

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

Physician

A licensed Doctor of Medicine (M.D.) or Osteopathy (D.O.).

Placement for Adoption; Placement

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

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.

Policy Anniversary

January 1, 2026, and the same day of each following year.

Policyholder

The entity to whom this Group Policy is issued (see Title Page).

This policy has been updated effective January 1, 2025

Preferred Provider/PPO Provider

A Dentist contracted with a Dental Preferred Provider Organization (PPO) network identified by The Principal to this Group Policy.

The Policyholder participating 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.

The Principal has the right to terminate the Preferred Provider Organization (PPO) portion of this Group Policy if The Principal or the Preferred Provider Organization (PPO) terminates the arrangement.

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

Prevailing Charges

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

b. For dental care received from Non-Exclusive Providers/Non-Preferred Providers, the actual cost charged, but only to the extent that the actual cost charged does not exceed an amount that is equal to the negotiated fee amount described above.

Prior Plan

The group dental expense coverage of the Policyholder for which this Group Policy is a replacement.

Second Opinion

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

Covered Charges for:

This policy has been updated effective January 1, 2025

a. 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

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

Second Opinion Physician

A Physician or Dentist who is:

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

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

Signed or Signature

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 The Principal.

Treatment or Service

When used in this Group Policy, the term "Treatment or Service" will be considered to mean "treatment, service, substance, material, or device".

Written or Writing

A record which is on or transmitted by paper or electronic media, and which is consistent with applicable law.

This policy has been updated effective January 1, 2025

PART II - POLICY ADMINISTRATION

Section A - Contract

Article 1 - Entire Contract

This Group Policy, the current Certificate, the attached Policyholder application, and any Member applications make up the entire contract. The Principal is obligated only as provided in this Group Policy and is not bound by any trust or plan to which it is not a signatory party.

Article 2 - Policy Changes

Insurance under this Group Policy runs annually to the Policy Anniversary, unless sooner terminated. No agent, employee, or person other than an officer of The Principal has authority to change this Group Policy, and, to be effective, all such changes must be in Writing and Signed by an officer of The Principal.

The Principal reserves the right to change this Group Policy as follows:

a. Any or all provisions of this Group Policy may be amended or changed at any time, including retroactive changes, to the extent necessary to meet the requirements of any law or any regulation issued by any governmental agency to which this Group Policy is subject.

b. Any or all provisions of this Group Policy may be amended or changed at any time when The Principal determines that such amendment is required for consistent application of policy provisions.

c. By Written agreement between The Principal and the Policyholder, this Group Policy may be amended or changed at any time as to any of its provisions.

Any change to this Group Policy, including, but not limited to, those in regard to coverage, benefits, and participation privileges, may be made without the consent of any Member or Dependent.

Payment of premium beyond the effective date of the change constitutes the Policyholder's consent to the change.

Article 3 - Policyholder Eligibility Requirements

To be an eligible group and to remain an eligible group, the Policyholder must:

This policy has been updated effective January 1, 2025

a. be actively engaged in business for profit within the meaning of the Internal Revenue Code, or be established as a legitimate nonprofit corporation within the meaning of the Internal Revenue Code; and

b. make at least the level of premium contributions required for insurance on its eligible Members. The Policyholder must contribute at least 50% of the required premium for all Members (including disabled Members, if any); and

c. if the Member is to contribute part of the premium, maintain the following participation with respect to eligible employees and Dependents:

(1) Employees:

- at least 50% of all eligible employees must enroll;

(2) Dependents:

- maintain a Dependent participation of at least 50% of eligible Dependents; and

d. if the Member is to contribute no part of the premium, 75% of eligible employees and Dependents must enroll, excluding those who reject such coverage in Writing; and

e. insure five or more Members for Member Dental Expense Insurance to elect orthodontia.

For the purpose of determining the applicable participation shown in c. above, Members and Dependents who have existing coverage under other group insurance, Medicaid, TRICARE, or COBRA continuation will be removed from the calculation.

If a Policyholder had prior coverage with The Principal which coverage terminated due to nonpayment of premium, fraud or misrepresentation or material fact or failure to comply with minimum participation or employer contribution requirements, The Principal will not accept application from that Policyholder within 12 months after the date of such termination.

If the Policyholder has coverage for its employees with more than one carrier, the combined minimum participation is 75% of all eligible employees with the greater of 20% or five lives enrolled under this Group Policy. This requirement does not apply if the other coverage is issued by an affiliate of The Principal.

Article 4 - Policy Incontestability

In the absence of fraud, after this Group Policy has been in force two years, The Principal may not contest its validity except for nonpayment of premium.

This policy has been updated effective January 1, 2025

Article 5 - Individual Incontestability and Eligibility

All statements made by any individual insured under this Group Policy will be representations and not warranties. In the absence of fraud, these statements may not be used to contest an insured person's insurance unless:

a. the insured person's insurance has been in force for less than two years during the insured's lifetime; and

b. the statement is in Written form Signed by the insured person; and

c. a copy of the form which contains the statement is given to the insured or the insured's beneficiary at the time insurance is contested.

However, these provisions will not preclude the assertion at any time of defenses based upon the person's ineligibility for insurance under this Group Policy or upon the provisions of this Group Policy. In addition, if an individual's age is misstated, The Principal may at any time adjust premium and benefits to reflect the correct age.

The Principal may at any time terminate a Member's or Dependent's eligibility under this Group Policy:

a. 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

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

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

Article 6 - Information to be Furnished

The Policyholder must, upon request, give The Principal all information needed to administer this Group Policy. If a clerical error is found in this information, The Principal may at any time adjust premium to reflect the facts. An error will not invalidate insurance that would otherwise be in force. Neither will an error continue insurance that would otherwise be terminated.

This policy has been updated effective January 1, 2025

The Principal may inspect, at any reasonable time, all Policyholder records which relate to this Group Policy.

Article 7 - Certificates

The Principal will give the Policyholder Certificates for delivery to insured Members. The delivery of such Certificates will be in either paper or electronic format. The Certificates will be evidence of insurance and will describe the basic features of the benefit plan. They will not be considered a part of this Group Policy.

Article 8 - Workers' Compensation Not Affected

This Group Policy is not in place of and does not affect nor fulfill the requirements for Workers' Compensation Insurance.

Article 9 - Dependent Rights

A Dependent will have no rights under this Group Policy except as set forth in PART III, Section D, Article 2.

Article 10 - State Required Notice - California

If The Principal increases a premium, reduces or eliminates benefits, or restricts eligibility, The Principal must mail advance notice to:

a. the insurance producer and administrator, if any, 45 days before the effective date of termination; and

b. the Policyholder 60 days before the effective date of termination.

Article 11 - Electronic Transactions

Any transaction relating to this Group Policy may be conducted by electronic means if performance of the transaction is consistent with applicable state and federal law.

Any notice required by the provisions of this Group Policy given by electronic means will have the same force and effect as notice given in writing.

This policy has been updated effective January 1, 2025

Article 12 - Value Added Service

The Principal reserves the right to offer or provide to a Policyholder a vision discount plan or any other value added service for the employees of the Policyholder. In addition, The Principal may arrange for third party service providers (i.e., optometrists, health clubs), to provide discounted goods and services to those Policyholders of The Principal. While The Principal has arranged these goods, services, and third party provider discounts, the third party service providers are liable to the Members for the provisions of such goods and services. The Principal is not responsible for the provision of such goods or services nor is it liable for the failure of the provision of the same. Further, The Principal is not liable to the Members for the negligent provisions of such goods and/or services by the third party service providers.

This policy has been updated effective January 1, 2025

Section B - Premiums

Article 1 - Payment Responsibility; Due Dates; Grace Period

The Policyholder is responsible for collection and payment of all premium due while this Group Policy is in force. Payments must be sent to the home office of The Principal in Des Moines, Iowa.

The first premium is due on the Date of Issue of this Group Policy. Each premium thereafter will be due on the first of each Insurance Month. Except for the first premium, a Grace Period of 60 days will be allowed for payment of premium. "Grace Period" means the first 60-day period following a premium due date. The Group Policy will remain in force until the end of the Grace Period, unless the Group Policy has been terminated by notice as described in this PART II, Section C. The Policyholder will be liable for payment of the premium for the time this Group Policy remains in force during the Grace Period.

Article 2 - Premium Rates

The premium rate for each Member insured for Dental Expense Insurance will be:

Member Without Dependents	$25.19
Member With Dependent Spouse or registered domestic partner	$52.54
Member With Dependent Children	$58.63
Member and All Dependents	$94.35

Article 3 - Premium Rate Changes

The Principal may change a premium rate on any of the following dates:

a. on any premium due date, if the initial premium rate has then been in force 12 months or more and if Written notice is given to the Policyholder at least 60 days before the date of change; or

b. on any date the definition of Member or Dependent is changed; or

c. on any date that a schedule of insurance or class of insured Members is changed.

If the Policyholder has other group insurance with The Principal, and if dental expense coverage is initially added on a date other than the Policy Anniversary and it is more than six months before the next Policy Anniversary, The Principal reserves the right to change the premium rate

on the next Policy Anniversary. Written notice will be given to the Policyholder at least 60 days before the date of change.

If the Policyholder agrees to participate in the electronic services program of The Principal and, at a later date elects to withdraw from participation, such withdrawal may result in certain administrative fees being charged to the Policyholder.

Article 4 - Premium Amount

The amount of premium to be paid on each due date will be the sum of the premium rates then in effect for all Members then insured.

If a Member is added or a present Member's insurance is increased or terminated on other than the first of an Insurance Month, premium for that Member will be adjusted and applied as if the change were to take place on the first of the next following Insurance Month.

Article 5 - Contributions from Members

Members are not required to contribute a portion of the premium for their insurance under this Group Policy.

Members are not required to contribute a portion of the premium for their Dependent's insurance under this Group Policy.

This policy has been updated effective January 1, 2025

Section C - Policy Termination

Article 1 - Failure to Pay Premium

This Group Policy will terminate at the end of the Grace Period if total premium due has not been received by The Principal before the end of the Grace Period. Failure by the Policyholder to pay the premium within the Grace Period will be deemed notice by the Policyholder to The Principal to discontinue this Group Policy at the end of the Grace Period.

Article 2 - Termination for Cause

The Principal may terminate this Group Policy for cause by giving the Policyholder 60 days advance notice in Writing, with "cause" defined to be:

a. the Policyholder ceases to be an eligible group as described in this PART II, Section A; or

b. the Policyholder has made a material misrepresentation to or committed an act of fraud against The Principal.

Article 3 - Termination Without Regard to Cause

The Policyholder may terminate this Group Policy effective on the day before any premium due date by giving Written notice to The Principal prior to that premium due date. The Policyholder's issuance of a stop-payment order for any amounts used to pay premiums for the Policyholder's insurance will be considered Written notice from the Policyholder.

The Principal may terminate this Group Policy without regard to cause by giving the Policyholder 60 days advance notice in Writing.

The Principal may terminate the Policyholder's coverage on any premium due date if the Policyholder relocates to a state where this Group Policy is not marketed, by giving the Policyholder 60 days advance notice in Writing.

Article 4 - Policyholder Responsibility to Members

If this Group Policy terminates for any reason, the Policyholder must:

a. mail promptly to each Member covered under this Group Policy a legible true copy of notice of cancellation of the Group Policy received from The Principal; and

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b. provide promptly to The Principal proof of that mailing and the date thereof; and

c. refund or otherwise account to each Member all contributions received or withheld from Members for premiums not actually paid to The Principal.

Article 5 - Responsibility of The Principal

If The Principal terminates this Group Policy for any reason, The Principal must mail advance notice to:

a. the insurance producer and administrator, if any, 45 days before the effective date of termination; and

b. the Policyholder 60 days before the effective date of termination.

This policy has been updated effective January 1, 2025

Section D - Policy Renewal

Article 1 - Renewal

Insurance under this Group Policy runs annually to the Policy Anniversary, unless sooner terminated.

While this Group Policy is in force, and subject to the provisions in this PART II, Section C, the Policyholder may renew at the applicable premium rates in effect on the Policy Anniversary.

This policy has been updated effective January 1, 2025

PART III - INDIVIDUAL REQUIREMENTS AND RIGHTS

Section A - Eligibility

Article 1 - Member Dental Expense Insurance

A person will be eligible for Member Dental Expense Insurance on the date the person becomes a Member as defined in PART I.

If a Member elects to waive coverage under this Group Policy because he or she is covered under group dental expense coverage or coverages provided by the Dependent's employer, the date such coverage terminates because the Dependent is no longer eligible under his/her employer's coverage will be considered the date the Member is eligible to request insurance as described in PART III, Section B of this Group Policy.

A Member may elect to insure his or her spouse or registered domestic partner or Domestic Partner as a Dependent even though such spouse or registered domestic partner or Domestic Partner is also insured under this Group Policy as a Member, provided the spouse or registered domestic partner or Domestic Partner otherwise qualifies as a Dependent and the Member remains insured for Member Dental Expense Insurance. With respect to such spouse or registered domestic partner or Domestic Partner, benefits payable shall be subject to the terms and conditions described in Coordination with Other Benefits in PART IV, Section D, and in no event shall exceed 100% of the charge for the covered Treatment or Service.

Article 2 - Dependent Dental Expense Insurance

A person will be eligible for Dependent Dental Expense Insurance on the latest of:

a. the date the person is eligible for Member Dental Expense Insurance; or

b. the date the person first acquires a Dependent.

Article 3 - Dental Health Maintenance Organization (DHMO) Coverage

A Member will not be eligible for Member or Dependent Dental Expense Insurance under this Group Policy while he or she is covered under a DHMO offered by the Policyholder as alternative coverage to this Group Policy.

This policy has been updated effective January 1, 2025

Section B - Effective Dates

Article 1 - Member Dental Expense Insurance

a. Actively at Work

A Member's effective date for Member Dental Expense Insurance will be as explained in this article, if the Member is Actively at Work on that date. If the Member is not Actively at Work on the date insurance would otherwise be effective, such insurance will not be in force until the day of return to Active Work.

This Actively at Work requirement will be waived for Members who:

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

This Actively at Work requirement may also be waived as described in Replacement of a Prior Plan in PART IV, Section C (1), of this Group Policy.

b. Effective Date for Noncontributory Insurance

Insurance for which the Member contributes no part of premium will be in force on the date the Member is eligible, unless a Member requests to waive coverage and is covered under another group dental expense coverage.

c. Effective Date for Contributory Insurance

If a Member is to contribute a part of premium, insurance must be requested in a form approved by The Principal. The effective date of requested insurance will be based on the Member's date of request.

(1) Request on or before the date eligible or within 31 days after the date eligible

Insurance will be in force on the date the Member is eligible if request is made on or before the date the Member is eligible or if coverage is requested within 31 days of the date the Member is eligible.

(2) Request more than 31 days after the date eligible

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Insurance will be in force on the first Policy Anniversary date following the date of the Member's request.

(3) Request more than 31 days after the date insurance terminates at the Member's request

Insurance will be in force on the next Policy Anniversary date following the date of the Member's request.

d. Annual Enrollment Period

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

(1) during the first period in which he or she was eligible to enroll, or during any subsequent Special Enrollment Period, as described in f. below; or
(2) during any previous Annual Enrollment Period; or
(3) within 31 days after the termination date, if the individual was previously insured under this Group Policy but elected to terminate such insurance.

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

(1) must meet the eligibility requirements described in this Group Policy, including satisfaction of any applicable waiting period; and
(2) may not be covered under an alternate dental expense plan 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 accepted by The Principal.

The effective date for any such individual requesting insurance during the Annual Enrollment Period will be January 1 following completion of the Annual Enrollment Period provided premium has been paid for the requested insurance.

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

(1) the Member is enrolled (or is eligible to be enrolled but has failed to enroll during a previous enrollment period); and

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(2) the Member has failed to enroll the Dependent Child during a previous enrollment period; and
(3) the Member is required by a QMCSO or NMSN as defined by applicable federal law and state insurance laws to provide dental coverage for the Dependent Child.

The request for enrollment:

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

The effective date of the Member's or Dependent Child's insurance:

(1) will be the date of the request for enrollment; and
(2) 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 this Group Policy.

f. Special Enrollment Period

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

The Special Enrollment Periods are:

(1) Loss of Other Coverage: A Special Enrollment Period will apply to a Member or Dependent if all of the following conditions are met:

(i) the individual (Member or Dependent) 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 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 date of the request for enrollment provided premium has been paid for the requested insurance.

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NOTE: For the purpose of (1) (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 coverage 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.

(2) Newly Acquired Dependents: A Special Enrollment Period will apply to a Member or Dependent if:

(i) the Member is enrolled (or is eligible to be enrolled but has failed to enroll during a previous enrollment period); and
(ii) a person becomes a Dependent of the Member 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 this Group Policy, if the request is made on or before the event or within 31 days after the event.

The effective date of the Member's or 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.

g. Effective Date for Benefit Changes - Change in Member Status

A change in a Member's Scheduled Benefits because of a change in the Member's status (insurance class) will normally be effective on the date of the change in status. However, if the Member is not Actively at Work on the date a Scheduled Benefit change would

otherwise be effective, the Scheduled Benefit change will not be in force until the date the Member returns to Active Work.

Any termination of Scheduled Benefits due to a change in a Member's status (insurance class) will be effective on the date of the change in status, whether or not the Member is Actively at Work.

h. Effective Date for Benefit Changes - Change by Policy Amendment

A change in the amount of a Member's Scheduled Benefits because of a change in the Schedule of Insurance (as described in PART IV, Section A) by amendment to this Group Policy will be effective on the date of change. However, if the Member is not Actively at Work on the date a Scheduled Benefit change would otherwise be effective, the Scheduled Benefit change will not be in force until the date the Member returns to Active Work.

i. Effective Date for Benefit Changes - Change in Benefits Made by The Principal

A change in a Member's Scheduled Benefits because of a change made by The Principal will normally be effective on the Policyholder's Policy Anniversary. However, if the Member is not Actively at Work on the date a Scheduled Benefit change would otherwise be effective, the Scheduled Benefit change will not be in force until the date the Member returns to Active Work.

Article 2 - Dependent Dental Expense Insurance

Dependent Dental Expense Insurance is available only with respect to Dependents of Members currently insured for Member Dental Expense Insurance. If a Member is eligible for Dependent Dental Expense Insurance, such insurance will be effective under the same terms as set forth for Member Dental Expense Insurance in this Section B, Article 1 except:

a. A Member will be insured with respect to a new Dependent on the date the Dependent is acquired, if Dependent Dental Expense Insurance is then in force for any other Dependent of the Member.

b. The Actively at Work requirement will apply only to Member insurance.

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

a. the date insurance would have become effective for a Dependent under the terms of this Group Policy; or

b. the date The Principal approves the Domestic Partner's status as a Dependent.

This policy has been updated effective January 1, 2025

Article 2A - Automatic Insurance for Newborns and Newly Adopted Children

If, while Member Dental Expense Insurance is in force for a Member, the Member acquires 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 the Member has applied for Dependent insurance.

If the Member is already insured for Dependent insurance, no further application is required to continue the child's insurance. If the Member is not already insured for Dependent insurance, the Member 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.

Article 3 - Dental Health Maintenance Organization (DHMO) Coverage

The provisions of this article apply if the Policyholder offers coverage under a DHMO as an alternative to coverage under this Group Policy.

A person who would otherwise be eligible for coverage under this Group Policy, as provided in this PART III, Section A, may transfer from a DHMO to this Group Policy on:

a. Any Annual Enrollment Period designated by the Policyholder for such transfer.

b. Any date the Member is transferred or otherwise changes residence to outside a DHMO service area; or on any date the DHMO ceases to operate.

Any transfer from a DHMO to this Group Policy will not be subject to the Actively at Work requirements discussed in this PART III, Section B.

Persons transferring to this Group Policy from a DHMO as provided in a. and b. above must provide proof of enrollment in the DHMO. Enrollment must have terminated on the day before the date of transfer to this Group Policy.

This policy has been updated effective January 1, 2025

Section C - Individual Terminations

Article 1 - Member Dental Expense Insurance

Unless continued as provided in Section D - Continuation, a Member's coverage under this Group Policy will terminate on the earliest of:

a. the date this Group Policy is terminated; or

b. one month following the end of the Insurance Month for which the last premium is paid for the Member's insurance; or

c. for contributory insurance, the end of any Insurance Month desired, if requested by the Member before that date; or

d. one month following the end of the Insurance Month in which the Member ceases to be a Member as defined in PART I; or

e. one month following the end of the Insurance Month in which the Member ceases to be in a class for which Member Dental Expense Insurance is provided; or

f. one month following the end of the Insurance Month in which the Member ceases Active Work; or

g. the date the Member transfers to a DHMO offered by the Policyholder as an alternative to coverage under this Group Policy.

Article 2 - Dependent Dental Expense Insurance

Unless continued as provided in Section D - Continuation, a Member's coverage under this Group Policy for a Dependent will terminate on the earliest of:

a. the date his or her Member Dental Expense Insurance terminates; or

b. the date Dependent Dental Expense Insurance is removed from this Group Policy; or

c. the end of the Insurance Month for which the last premium is paid for the Member's Dependent Dental Expense Insurance; or

d. for contributory insurance, the end of any Insurance Month desired, if requested by the Member before that date; or

This policy has been updated effective January 1, 2025

e. the end of the Insurance Month in which the Member ceases to be in a class for which Dependent Dental Expense Insurance is provided; or

f. for each spouse, state registered domestic partner or Dependent Child, on the last day of the Insurance Month in which that spouse, state registered domestic partner or Dependent Child ceases to be a Dependent as defined in PART I. 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 continues to be a Dependent as defined in PART I; or

g. 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 as defined in PART I. 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 The Principal, provided the Domestic Partner otherwise continues to be a Dependent as defined in PART I.

This policy has been updated effective January 1, 2025

Section D - Continuation

Article 1 - Member Dental Expense Insurance

a. Sickness or Injury

If Active Work ends because a Member is sick or injured, insurance for that Member may be continued until the earliest of:

(1) the date insurance would otherwise cease as provided in PART III, Section C; or
(2) the end of the Insurance Month in which the Member recovers; or
(3) the end of the Insurance Month in which the Member is covered under the USERRA continuation provision; or
(4) the end of the Insurance Month after coverage has been continued under this Section for 12 consecutive months.

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

b. Layoff or Approved Leave of Absence

If Active Work ends because a Member is on layoff or approved leave of absence, insurance for that Member may be continued until the earliest of:

(1) the date insurance would otherwise cease as provided in PART III, Section C; or
(2) the end of the Insurance Month in which the layoff or approved leave of absence ends; or
(3) the date the Member becomes eligible for any other group dental expense coverage; or
(4) the date one month after the end of the Insurance Month in which Active Work ends.

In addition, a longer continuation period will be allowed for an approved leave of absence taken in accordance with the provisions of the state law regarding family leave.

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

c. State Required - California

A Member's Dental Expense Insurance may also be continued as described in Article 3, State Required Continuation.

This policy has been updated effective January 1, 2025

Article 2 - Dependent Dental Expense Insurance

a. During Continuation of Member Insurance

Except as otherwise provided in PART III, Section C, Dependent Dental Expense Insurance may remain in force during any period that Member Dental Expense Insurance is continued.

b. Developmentally Disabled or Physically Handicapped Children

(1) Qualification

Dental Expense Insurance for a child may be continued after the child reaches the maximum age for Dependent Children as defined in PART I of this Group Policy, provided that:

- the child is incapable of self-support as the result of a Developmental Disability or Physical Handicap and became so before reaching the maximum age and is dependent on the Member for primary support; and
- except for age, the child continues to be a Dependent Child as defined in PART I; and
- proof of the child's incapacity is sent to The Principal within 60 days after the date The Principal has notified the Member that the child will be reaching the maximum age; and
- further proof that the child remains incapable of self-support is provided when The Principal requests but not more frequently than annually after the two year period following the child's attainment of the maximum age; and
- the child undergoes examination by a Physician when The Principal requests. The Principal will pay for these examinations and will choose the Physician to perform them.

The Principal will provide notice to the Member that a Dependent Child's coverage will terminate upon reaching the maximum age at least 90 days prior to that date unless the Member submits the information described above.

(2) Period of Continuation

Insurance for a Dependent Child who qualifies as set forth above may be continued until the earlier of:

- the date insurance would cease for any reason other than the child's attainment of the maximum age; or

This policy has been updated effective January 1, 2025

- the date the child becomes capable of self-support or otherwise fails to qualify as set forth in (1) above.

c. State Required - California

A Dependent's Dental Expense Insurance may also be continued as described in Article 3, State Required Continuation.

d. Continuation for state registered domestic partners or Domestic Partners (and any Dependent Children)

(1) 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), this Group Policy is in force, the person was insured under this 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:

(i) an insured state registered domestic partner or Domestic Partner (and any Dependent Children) following the Member's:

- termination of employment for a reason other than gross misconduct; or

- 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, 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 or Domestic Partner to qualify for this group dental continuation); and

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

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

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

(2) Maximum Continuation Period

This policy has been updated effective January 1, 2025

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 or 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 (4)).

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 or Domestic Partner will be the longer of:

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

(ii) 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 (1) (ii) through (1) (iv) is 36 months from the date of the qualifying event.

(3) 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 (1), (ii) through (1), (iv) 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 (1), (ii) through (1), (iv), absent the first qualifying event, would result in a loss of coverage for the covered state registered domestic partner or Domestic Partner under this Group Policy.

(4) 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.

This policy has been updated effective January 1, 2025

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 (5) below.

(5) Termination of Continued Coverage

Continued coverage ends the earliest of the following:

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

(ii) 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

(iii) 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 (9)); or

(iv) the date this Group Policy is terminated; or

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

(vi) 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

(vii) the date the Member is no longer covered under COBRA as described in (1), (i).

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.

(6) Employer/Plan Administrator Notification Requirement

When a covered state registered domestic partner or 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, 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.

This policy has been updated effective January 1, 2025

(7) 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 or Domestic Partnership under the terms of this 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 or Domestic Partner. Retain copies of any notices sent to the plan administrator.

This policy has been updated effective January 1, 2025

(8) Monthly Cost

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

(9) 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.

(10) Policy Changes

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

(11) 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 this Group Policy or group dental continuation, contact the following:

Group Dental Plan:	UC POSTDOCTORAL SCHOLAR Dental Plan
Contact Name/Area:	GALLAGHER BENEFIT SERVICES INC
Address:	ATTN: PSBP CUSTOMER SERVICE
	18201 VON KARMAN AVE STE 200
Phone Number:	IRVINE CA 92612
	TOLL FREE: 1-800-254-1758

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.

Article 3 - State Required Continuation - California

This policy has been updated effective January 1, 2025

a. Member Continuation

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)

(i) Definitions

Qualified Person means a Member or any covered Dependent who, on the day before a Qualifying Event, is covered under this 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 otherwise cease due to the Member's termination of employment or reduction in work hours for reasons other than gross misconduct.

(ii) Qualification for Continuation

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

- this 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 federal continuation (COBRA).

(iii) Period of Continuation

Insurance for a Qualified Person who qualifies as set forth above may be continued until the earliest of:

- the date this Group Policy is terminated; or
- the date insurance would otherwise cease as provided in PART III, Section C; 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

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- the date the Qualified Person becomes covered or eligible for federal continuation (COBRA); or
- the date insurance has been continued for 36 months.

Note: 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.

(iv) Notice, Election, and Premium Requirements

- **Policyholder Notice Requirements**

  The Policyholder must notify The Principal within 30 days of a Qualifying Event or when the Policyholder becomes subject to the federal continuation law (COBRA).

  If this Group Policy terminates, the Policyholder must notify Qualified Persons of the termination and of the ability to remain covered under a replacing plan, if any. The notice to Qualified Persons must be provided the later of: 30 days prior to the date of termination of this Group Policy or when active Members are notified. The Policyholder must notify the replacing carrier in writing of the names of all Qualified Persons. Within 15 days of a written request, The Principal will provide the Policyholder or the agent or broker representative information necessary to fulfill the Policyholder and replacing carrier notice obligations.

- **Qualified Person Notice Requirements**

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

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

- **Election Requirements**

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

This policy has been updated effective January 1, 2025

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

- **Premium Requirements**

  Premium charged for the continuation will be 110% of the applicable group rate.

  The first premium payment must be delivered to The Principal by first class or certified mail (or other reliable means) within 45 days after the date the Qualified Person elects continuation. 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.

b. Dependent Continuation

(1) 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)

(i) Definitions

Qualified Person means a Dependent who, on the day before a Qualifying Event, is covered under this 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 of his or her state registered domestic partnership or Domestic Partnership; or

This policy has been updated effective January 1, 2025

- the Member's option to terminate insurance under this Group Policy upon his or her becoming entitled to Medicare; or
- a Member's child ceasing to be a Dependent Child as defined in this Group Policy.

(ii) Qualification for Continuation

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

- this 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 federal continuation (COBRA).

(iii) Period of Continuation

Insurance for a Qualified Person who qualifies as set forth above may be continued until the earliest of:

- the date this Group Policy is terminated; or
- the date insurance would otherwise cease as provided in PART III, Section C; 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 federal continuation (COBRA); or
- the date insurance has been continued for 36 months.

(iv) Notice, Election, and Premium Requirements

- **Policyholder Notice Requirements**

  The Policyholder must notify The Principal within 30 days after becoming subject to the federal continuation law (COBRA).

This policy has been updated effective January 1, 2025

If this Group Policy terminates, the Policyholder must notify Qualified Persons of the termination and of the ability to remain covered under a replacing plan, if any. The notice to Qualified Persons must be provided the later of, 30 days prior to the date of termination of this Group Policy, or when active Members are notified. The Policyholder must notify the replacing carrier in writing of the names of all Qualified Persons. Within 15 days of a written request, The Principal will provide the Policyholder or the agent or broker representative information necessary to fulfill the Policyholder and replacing carrier notice obligations.

- **Qualified Person Notice Requirements**

  Qualified Persons must notify The Principal within 30 days any Qualifying Event.

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

- **Election Requirements**

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

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

- **Premium Requirements**

  Premium charged for the continuation will be 110% of the applicable group rate.

  The first premium payment must be delivered to The Principal by first class or certified mail (or other reliable means) within 45 days after the

date the Qualified Person elects continuation. 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.

Article 4 - Federal Required Continuation

a. Consolidated Omnibus Budget Reconciliation Act (COBRA)

COBRA applies to any employer (excepting the federal government and religious organizations) who:

(1) maintains a group dental coverage; and
(2) 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.

Federal law requires that certain group health plans allow qualified persons who would otherwise lose coverage under this Group Policy as a result of a qualifying event, to elect to continue group coverage under this Group Policy. If coverage under this Group Policy is continued under Article 1, Article 2, or Article 3 above, the continuation coverage provided under COBRA will run concurrently with such continuation provisions.

A full description of the COBRA continuation provisions is included in the administration material provided to the Policyholder and in the booklet-certificate.

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.

Coverage may be extended beyond the COBRA continuation period as described above in Article 3 - State Required - California.

b. Family and Medical Leave Act (FMLA)

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 policy has been updated effective January 1, 2025

This is a general summary of the FMLA and how it affects this Group Policy. A full description of the FMLA continuation provisions is included in the administration material provided to the Policyholder.

(1) FMLA and Other Continuation Provisions

These FMLA continuation provisions:

- are in addition to any other continuation provisions described in this Group Policy, if any; and
- will run concurrently with any other continuation provisions described in this 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.

(2) 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.

(3) 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).

(4) 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;

This policy has been updated effective January 1, 2025

- 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.

(5) Reinstatement

An Eligible Employee's terminated insurance may be reinstated in accordance with the provisions of the FMLA, subject to the Actively at Work provisions described in PART III, Section B.

c. Uniform Services Employment and Reemployment Rights Act of 1994 (USERRA)

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

Such continued insurance will terminate on the earliest of:

(1) for a Member and his or her Dependents:

- the date this Group Policy is terminated; or
- the end of the premium period for which premium is paid if the Member fails to make timely payment of a required premium; or
- the date 24 months after the date the Member enters active military duty; or

- the date after the day in which the Member fails to return to Active Work or apply for reemployment with the Policyholder.

(2) for a Member's Dependents:

- the date Dependent Dental Expense Insurance would otherwise cease as provided in PART III, Section C; or
- the end of any Insurance Month desired, if requested by the Member before that date.

Continuation provisions described in this Group Policy for sickness, injury, layoff, or approved leave of absence, if any, may apply. These continuation provisions, however, will terminate on the end of the Insurance Month in which the Member is covered under the USERRA continuation provision. If the Member qualifies for USERRA, COBRA, or state 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.

The reinstatement time period, as provided in this PART III, Section E, 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 provisions, described in PART III, Section B, will not apply to the reinstated insurance.

This is a general summary of the USERRA and how it affects this Group Policy. A full description of the USERRA continuation provisions is included in the administration material provided to the Policyholder.

This policy has been updated effective January 1, 2025

Section E - Reinstatement

Article 1 - Reinstatement

A Member's terminated insurance will be reinstated if:

a. insurance ceased because of layoff or approved leave of absence; and

b. the Member returns to Active Work for the Policyholder within six months of the date insurance ceased.

The Member's reinstated insurance will be in force on the date of return to Active Work. However, the Actively at Work provision discussed in this PART III, Section B, will apply.

Only the period of time during which a Member is actually insured will be included in determining the length of his or her continuous coverage under this Group Policy. For this purpose the period of time during which a reinstated Member's insurance was not in force:

a. will not be considered an interruption of continuous coverage; and

b. will not be used to satisfy any provision of this Group Policy which pertains to a period of continuous coverage.

In addition, a longer reinstatement period will be allowed for an approved leave of absence taken in accordance with the provisions of the state law regarding family leave.

If the Policyholder offers coverage under a DHMO as an alternative to coverage under this Group Policy, these reinstatement provisions will not apply to a Member who is covered under a DHMO on the date insurance terminates, except with respect to any insurance for which the Member was insured under this Group Policy on the date his or her insurance terminated.

This policy has been updated effective January 1, 2025

PART IV - BENEFITS

Section A - Dental Expense Insurance (General Provisions)

Article 1 - Schedule of Insurance

a. Insurance Class

Subject to the Effective Date provisions of PART III, Section B, Scheduled Benefits for Members and Dependents will be:

Class	Scheduled Benefits
All Members and All Dependents	Dental benefits as described in this PART IV, Section B (1C), for Covered Charges under Dental Care Units 1, 2, 3, and 4.

b. Dental Care Units

Treatment or Service for which benefits are payable under this Group Policy are divided into Dental Care Units:

Preventive Procedures	Unit 1
Basic Procedures	Unit 2
Major Procedures	Unit 3
Orthodontia	Unit 4

c. Maximum Benefits

Benefit payment provided under this PART IV, Section B (1C), for a Member or Dependent will not exceed:

Covered Charges	Maximum Payment Limit

This policy has been updated effective January 1, 2025

Dental Care Units 1, 2, and 3	$1,700 each Calendar Year for dental care received from Exclusive Providers and $1,700 each Calendar Year for dental care received from Preferred Providers and $1,500 each Calendar Year for dental care received from Non-Exclusive Providers/Non-Preferred Providers
Dental Care Unit 4	$1,000 lifetime for dental care received from Exclusive Providers and $1,000 lifetime for dental care received from Preferred Providers and $1,000 lifetime 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.

Article 2 - Benefit Qualification

A Member or Dependent will qualify for payment of the benefits provided for an insurance class if:

a. he or she is insured in that class on the date dental Treatment or Service is received; and

b. the claim requirements of PART IV, Section C, are satisfied.

Article 3 - Benefits Payable

Benefits payable under this Group Policy will be as described in this PART IV, Section (1C), subject to:

a. the limitations listed in this PART IV, Section B (1B); and

b. the terms and conditions set forth in this PART IV, Section D.

Article 3A - 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.

This policy has been updated effective January 1, 2025

Section B (1C) - Dental Expense Insurance (POS)

Article 1 - Payment Conditions

If a Member or Dependent receives any Treatment or Service that is listed in this PART IV under the Schedule of Dental Procedures, The Principal will pay the charges for that Treatment or Service. The benefits payable for all listed Treatment or Service received will be as described below.

The total benefit payment for each Member and Dependent will not be more than the Dental Maximum Payment Limit(s).

a. **Exclusive Providers**

If dental care is received from Exclusive Providers, benefits payable will be:

(1) Dental Care Unit 1

100% of Covered Charges each Calendar Year described in this section.

(2) Dental Care Unit 2

90% of Covered Charges each Calendar Year in excess of the Deductible Amount described in this section.

(3) Dental Care Unit 3

60% of Covered Charges each Calendar Year in excess of the Deductible Amount described in this section.

(4) Dental Care Unit 4

50% of Covered Charges up to the lifetime Maximum Payment Limit described in this section.

b. **Preferred Providers**

If dental care is received from Preferred Providers, benefits payable will be:

(1) Dental Care Unit 1

100% of Covered Charges each Calendar Year described in this section.

This policy has been updated effective January 1, 2025

(2) Dental Care Unit 2

90% of Covered Charges each Calendar Year described in this section.

(3) Dental Care Unit 3

50% of Covered Charges each Calendar Year described in this section.

(4) Dental Care Unit 4

50% of Covered Charges up to the lifetime Maximum Payment Limit described in this section.

c. **Non-Exclusive Providers/Non-Preferred Providers**

If dental care is received from Non-Exclusive Providers or Non-Preferrerd Providers, benefits payable will be:

(1) Dental Care Unit 1

100% of Covered Charges each Calendar Year described in this section.

(2) Dental Care Unit 2

80% of Covered Charges each Calendar Year in excess of the Deductible Amount described in this section.

(3) Dental Care Unit 3

50% of Covered Charges each Calendar Year in excess of the Deductible Amount described in this section.

(4) Dental Care Unit 4

50% of Covered Charges up to the lifetime Maximum Payment Limit described in this section.

Article 2 - Deductible Amount

a. Exclusive Providers - Individual

This policy has been updated effective January 1, 2025

If dental care is received from Exclusive Providers, the individual Deductible Amount for each Member or Dependent will be:

(1) none with respect to Covered Charges under Dental Care Unit 1; and
(2) none with respect to Covered Charges under Dental Care Unit 2; and
(3) none with respect to Covered Charges under Dental Care Unit 3; and
(4) none with respect to Covered Charges under Dental Care Unit 4.

b. Preferred Providers - Individual

If dental care is received from Preferred Providers, the individual Deductible Amount for each Member or Dependent each Calendar Year will be:

(1) none with respect to Covered Charges under Dental Care Unit 1; and
(2) none with respect to Covered Charges under Dental Care Unit 2; and
(3) none with respect to Covered Charges under Dental Care Unit 3; and
(4) none with respect to Covered Charges under Dental Care Unit 4.

c. Non-Exclusive Providers/Non-Preferred Providers - Individual

If dental care is received from Non-Exclusive Providers or Non-Preferred Providers, the individual Deductible Amount for each Member or Dependent each Calendar Year will be:

(1) none with respect to Covered Charges under Dental Care Unit 1; and
(2) $50 with respect to Covered Charges under Dental Care Units 2 and 3 (in combination) each Calendar Year; and
(3) none with respect to Covered Charges under Dental Care Unit 4.

For each Dental Care Unit, Covered Charges used to satisfy the Deductible that is applicable when care is received from Non-Exclusive Providers and 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 Providers 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:

(1) first, to Unit 1 charges; and
(2) then, to Unit 2 charges; and
(3) last, to Unit 3 charges.

Article 2A - 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, if the Member or Dependent receives 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.

Article 3 - Covered Charges

Covered Charges will be the actual cost charged to the Member or Dependent for Treatment or Service for the listed procedures described in this section under the Schedule of Dental Procedures but only to the extent that the actual cost charged does not exceed Prevailing Charges. Also:

a. 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

b. Covered Charges will include only those charges for Treatment or Service that begin (see Article 4 below) while the Member or Dependent is insured under this Group Policy; and

c. Covered Charges will include only those charges for Treatment or Service that is completed while the Member or Dependent is insured under this Group Policy, except when the Treatment or Service is covered under the Extended Benefits provision described in Article 6 below.

Article 4 - Beginning Date for Treatment or Service

Treatment or Service will be considered to begin on the applicable date shown below:

a. for root canal therapy, on the date the pulp chamber is opened and the pulp canal explored to the apex; and

b. for crowns, fixed bridgework, inlays, or onlay restoration, on the date the tooth or teeth are fully prepared; and

c. for complete or partial dentures, on the date the master impression is made; and

d. for orthodontia, on the date the appliance or bands are first set; and

e. for all other, on the date the Treatment or Service is performed.

Article 5 - Completion Date for Treatment or Service

Treatment or Service will be considered to be completed on the applicable date shown below:

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

b. for crowns, on the date the crown is seated; and

c. for fixed bridgework, on the date the bridge is seated; and

d. for inlay or onlay restorations, on the date the inlay or onlay is seated; and

e. for complete or partial dentures, on the date the complete or partial denture is seated.

Article 6 - Extended Benefits

a. Applicability

The Principal will pay Dental benefits for Treatment or Service described in b. below that is received by a Member or Dependent within 30 days after his or her insurance under this Group Policy is terminated, provided that:

(1) the Member or Dependent would have qualified for benefit payment under this section if insurance had remained in force; and
(2) the Treatment or Service began while the Member or Dependent was insured under this Group Policy; and
(3) at the time Treatment or Service is received, this Group Policy is in force.

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

These extended benefits will not apply to insurance which terminates because the Member or Dependent transfers to a DHMO.

This policy has been updated effective January 1, 2025

b. Qualified Treatment or Service

If the requirements of a. above are satisfied, extended benefits will be payable for:

(1) root canal therapy, but only if the pulp chamber was opened and the pulp canal explored to the apex while the Member or Dependent was insured under this Group Policy; and
(2) crowns, bridges, inlays, or onlay restorations, but only if the tooth or teeth were fully prepared while the Member or Dependent was insured under this Group Policy; and
(3) complete or partial dentures, but only if the master impression was made while the Member or Dependent was insured under this Group Policy.

This policy has been updated effective January 1, 2025

Section B (1B) - Dental Expense Insurance - Limitations

Article 1 - Limitations

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

a. Treatment or Service that is not a Covered Charge; or

b. the services of any person who is not a Dentist or Dental Hygienist; or

c. any part of a charge for Treatment or Service that exceeds Prevailing Charges; or

d. the services of any person who is in an insured person's Immediate Family; or

e. implants; or

f. Treatment or Service that does not meet professionally recognized standards of quality; or

g. veneers, anterior 3/4 cast crowns, personalization of dentures or crowns (or any other Treatment or Service that is primarily cosmetic); or

h. drugs, medicines, or therapeutic drug injections when not billed as part of a listed Covered Charge described in this PART IV, Section B (1C), under Dental Care Units 1, 2, 3, and 4; or

i. instructions for plaque control, oral hygiene, or diet or nutritional counseling when billed as a separate Treatment or Service from examinations; or

j. bite registration or occlusal analysis; or

k. Treatment or Service to alter or maintain vertical dimension or restore or maintain occlusion; or

l. Treatment or Service for the purpose of duplicating a prosthetic device or replacing any such device that is lost or stolen; or

m. Treatment or Service for the purpose of duplicating an appliance or replacing any such appliance that is lost or stolen; or

n. Orthodontic Treatment or Service; if the appliance or bands were placed prior to being insured under this Group Policy, unless the Member or Dependent is currently in a treatment plan which was covered under prior group orthodontic coverage, and there has been no Lapse in Coverage; or

This policy has been updated effective January 1, 2025

o. Treatment or Service for provisional or permanent splinting; or

p. Treatment or Service for which the Member or Dependent has no financial liability or that would be provided at no charge or at a different charge in the absence of insurance; or

q. Treatment or Service that is temporary; or

r. 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

s. Treatment or Service that results from a sickness that is paid under a Workers' Compensation Act or other similar law; or

t. 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 Policyholder who are not covered by a Workers' Compensation Act or other similar law; or

u. Treatment or Service that results from war or act of war; or

v. Treatment or Service that results from commission of or attempted commission of a felony or voluntary participation in an illegal occupation; or

w. Treatment or Service provided outside the United States, unless the Member or Dependent are outside the United States for one of the following reasons:

(1) travel, provided the travel is for a reason other than securing dental care diagnosis or treatment; or
(2) a business assignment, provided the Member or Dependent are temporarily outside the United States; or
(3) 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

x. Treatment or Service replacing tooth structure lost from abrasion, attrition, erosion, or abfraction; or

y. 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

This policy has been updated effective January 1, 2025

z. 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

aa. Treatment or Service that is paid for by a Medicare Supplement Insurance Plan; or

bb. Treatment or Service for temporomandibular joint disorders, except as provided for occlusal guards; or

cc. charges by an anesthesiologist for services that were performed in facilities other than a dental office; or

dd. emergency room charges or outpatient facility charges (including but not limited to hospital outpatient facility charges); or

ee. 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 this Group Policy; or

ff. charges that are billed incorrectly or separately for Treatment or Services that are an integral part of another billed Treatment or Service.

Section B (2) - Dental Expense Insurance - Schedule of Dental Procedures - Unit 1

Article 1 - Schedule of Dental Procedures

Unless The Principal agrees otherwise, Covered Charges will include only charges for procedures listed in this PART IV, Section B (2). If a non-listed procedure is accepted, The Principal will determine its maximum allowance based on the Prevailing Charges for a listed procedure of comparable nature.

Article 2 - Dental Care Unit 1 - Preventive Procedures

Covered Charges will be the actual cost charged to the Member or Dependent for Treatment or Service for the listed procedures described in this article 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 this Group Policy remain in full force and effect with respect to benefits.

Radiographs

Full Mouth Survey

This policy has been updated effective January 1, 2025

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.

This policy has been updated effective January 1, 2025

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.

Other Services

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.

This policy has been updated effective January 1, 2025

Section B (3) - Dental Expense Insurance - Schedule of Dental Procedures - Unit 2

Article 1 - Schedule of Dental Procedures

Unless The Principal agrees otherwise, Covered Charges will include only charges for procedures listed in this PART IV, Section B (3). If a non-listed procedure is accepted, The Principal will determine its maximum allowance based on the Prevailing Charges for a listed procedure of comparable nature.

Article 2 - Dental Care Unit 2 - Basic Procedures

Covered Charges will be the actual cost charged to the Member or Dependent for Treatment or Service for the listed procedures described in this article 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 in Section B (4). 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, intra-operative 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 the Member or Dependent is 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

This policy has been updated effective January 1, 2025

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

This policy has been updated effective January 1, 2025

Anesthesia

General anesthesia
IV sedation

General anesthesia or IV sedation is payable for the following covered services when performed in the 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.

Occlusal Guard

Limited to one guard per 36 months or if necessary to replace due to the placement of bridgework or three or more posterior crowns after the placement of the guard.

This policy has been updated effective January 1, 2025

Section B (4) - Dental Expense Insurance - Schedule of Dental Procedures - Unit 3

Article 1 - Schedule of Dental Procedures

Unless The Principal agrees otherwise, Covered Charges will include only charges for procedures listed in this PART IV, Section B (4). If a non-listed procedure is accepted, The Principal will determine its maximum allowance based on the Prevailing Charges for a listed procedure of comparable nature.

Article 2 - Dental Care Unit 3 - Major Procedures

Covered Charges will be the actual cost charged to the Member or Dependent for Treatment or Service for the listed procedures described in this article but only to the extent that the actual cost charged does not exceed Prevailing Charges.

Dental Procedure

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

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 60 consecutive months have elapsed since the last placement.

This policy has been updated effective January 1, 2025

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 60 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 60 consecutive months have elapsed since the last placement of the restoration. For persons under 16 years of age, the benefit for crowns 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 60 consecutive months has 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 60 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

This policy has been updated effective January 1, 2025

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 60 consecutive month period.

Prosthodontics, Fixed

Fixed bridges - initial placement or replacement

Coverage for bridges limited to persons over age 16.

Benefits for the replacement of an existing fixed bridge are payable only if the existing bridge is more than 60 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

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

This policy has been updated effective January 1, 2025

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.

Section B (5) - Dental Expense Insurance - Schedule of Dental Procedures - Unit 4

Article 1 - Schedule of Dental Procedures

Unless The Principal agrees otherwise, Covered Charges will include only charges for procedures listed in this PART IV, Section B (5). If a non-listed procedure is accepted, The Principal will determine its maximum allowance based on the Prevailing Charges for a listed procedure of comparable nature.

Article 2 - Dental Care Unit 4 - Orthodontia

Covered Charges will be the actual cost charged to the Member or Dependent for Treatment or Service for the listed procedures described in this article but only to the extent that the actual cost charged does not exceed Prevailing Charges.

Dental Procedure

Orthodontic Services

Formal, full-banded retention and treatment, including x-rays and other diagnostic procedures.

Removable or fixed appliances for tooth or bony structure guidance or retention.

This policy has been updated effective January 1, 2025

Section C - Claim Procedures

Article 1 - Notice of Claim

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

Article 2 - Claim Forms

The Principal, when it receives notice of claim, will provide claim forms, instructions, and reasonable assistance within 15 calendar days of receipt of such notice.

Article 3 - Proof of Loss

Written proof of loss must be sent to The Principal within 12 months after the date of the loss. For purposes of satisfying the claim processing requirements, receipt of claim will be considered to be met when The Principal receives proof of loss. Proof of loss includes the patient's name, Member's name (if different from the patient's name), provider of services, dates of service, diagnosis, description of Treatment or Service provided and the extent of the loss. The Principal may request additional information to substantiate loss or require a Signed unaltered authorization to obtain that information from the provider. Failure to comply with The Principal's request could result in declination of the claim. The Principal may also require x-rays, dental charts, and other evidence needed to determine the dental condition treated and the services provided.

Article 4 - 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, The Principal will send a Written explanation prior to the expiration of the 30 calendar days. If The Principal does not deny the claim and requests additional information to complete the review, the claimant is then allowed up to 45 calendar days to provide all additional information requested. The Principal 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 this Group Policy may be payable sooner, provided The Principal receives complete and proper proof of loss. If a claim is not payable or cannot be processed, The Principal will submit a detailed explanation of the basis for its denial.

This policy has been updated effective January 1, 2025

A claimant may request an appeal of a claim denial by Written request to The Principal within 180 calendar days of receipt of the notice of denial. The Principal will make a full and fair review of the claim. The Principal may require additional information to make the review. The Principal 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 Member or 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, The Principal 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 The Principal 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, The Principal will notify the claimant in Writing of the basis for the denial. This denial notice will include an explanation of the policy provisions, 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.

Article 5 - Dental Treatment Plan

The Principal encourages the use of predeterminations to determine the extent of coverage for a proposed course of treatment. A Dental Treatment Plan may be filed with The Principal before treatment begins. Upon receipt, The Principal will provide a Written response indicating the benefits that may be payable for the proposed treatment. The Principal suggests 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 the Dentist, the insured, and The Principal as to how much will be paid for dental work. A Dental Treatment Plan is not a guarantee of what The Principal will pay. It informs the insured person and the Dentist, in advance, what The Principal will pay for a covered dental service named in the Dental Treatment Plan. If The Principal does not agree with a Dental Treatment Plan, The Principal has the right to base payments on treatment suited to the covered person's condition by accepted standards of dental practice.

Article 6 - Facility of Payment

This policy has been updated effective January 1, 2025

Benefits under this Group Policy for other than orthodontia will be payable immediately after The Principal receives complete and proper proof of loss. Benefits for orthodontia will be payable as described in Article 7 below.

The Principal will normally pay all benefits to the Member. However, if the claimed benefits are for dental care provided for a Dependent, The Principal may make payment to the Dependent. Also, in the special instances listed below, payment will be as indicated. All payments so made will discharge The Principal to the full extent of those payments.

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

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

c. Benefits payable to a PPO Provider will be paid directly to the PPO Provider on behalf of the Member or Dependent.

Note: When benefits under this 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.

Article 7 - Payment of Orthodontia Benefits

Benefits under this Group Policy for comprehensive orthodontia treatment will be payable in installments:

a. immediately upon receipt of proof that the initial treatment (including setting of the appliance or bands) has been completed; and

b. at the end of each following calendar month upon receipt of proof that the Period of Dental Treatment has continued.

The Covered Charge for the initial treatment will be 25% of the lesser of:

a. the Dental Care Unit 4 lifetime maximum; or

This policy has been updated effective January 1, 2025

b. Covered Charges as outlined in PART IV, Section B (5), Article 2 multiplied by the coinsurance shown in PART IV, Section B (1C), Article 1.

The monthly Covered Charge will be determined by averaging the remaining Covered Charge over the estimated time required to complete the Orthodontic Treatment or Service.

Treatment or Service for other than comprehensive orthodontia treatment may be paid in one lump sum.

The Dental Care Unit 4 Maximum Payment Limit under this Group Policy will be reduced by any orthodontia benefits paid under the Prior Plan.

For the purpose of this section, "Prior Plan" will mean the Member's group dental expense coverage for which this Group Policy is a replacement.

Orthodontia Treatment or Service will not be covered if the appliance or bands were placed prior to being insured under this Group Policy, unless:

a. the Member or Dependent is currently in a treatment plan which was covered under the Prior Plan; and

b. there has been no Lapse in Coverage; and

c. the Member or Dependent submits proof that:

(1) the Dental Care Unit 4 Maximum Payment Limit under this Group Policy was not exceeded under the Prior Plan; and
(2) the orthodontic treatment was started and bands or appliances were inserted while insured under the Prior Plan; and
(3) orthodontic treatment has been continued while the Member or Dependent is insured under this Group Policy.

Article 8 - Recoding of Procedures

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

This policy has been updated effective January 1, 2025

If The Principal determines 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.

Article 9 - Dental Examinations

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

Article 10 - Legal Action

Legal action to recover benefits under this Group Policy may not be started earlier than 90 calendar days after required proof of loss has been filed and before the appeal procedures have been exhausted. Further, no legal action may be started later than three years after that proof is required to be filed.

Article 11 - Time Limits

Any time limit listed in this section will be adjusted as required by law.

This policy has been updated effective January 1, 2025

Section C (1) - Replacement of a Prior Plan

Article 1 - Applicability

When insurance under this Group Policy replaces coverage under a Prior Plan, this section will apply to those Members and Dependents who:

a. are eligible and enrolled under this Group Policy on its Date of Issue; and

b. were covered under the Prior Plan on the date of its termination.

This section will also apply to any child, covered under the Prior Plan, which is not otherwise eligible under this Group Policy because the child does not receive principal support from the Member.

Article 2 - Benefits Payable

Benefits may be payable under this section when benefits under this Group Policy would otherwise be denied solely because of the Actively at Work provision, provided that:

a. benefits would have been paid under the Prior Plan had it remained in force; and

b. benefits are not paid under the Prior Plan due to its termination.

For Members who are not Actively at Work on the Date of Issue of this Group Policy and have not been Actively at Work since then, the benefits payable, if any, under this section will be the lesser of:

a. the benefits of this Group Policy; or

b. the benefits that would have been paid by the Prior Plan had it remained in force.

For Members who are Actively at Work on the Date of Issue of this Group Policy, the benefits payable under this section will be the benefits of the Group Policy.

In no event will benefits be paid for any Treatment or Service:

a. received before the Date of Issue of this Group Policy; or

b. for which benefits are paid under the Prior Plan; or

c. for which benefits would have been paid under the Prior Plan (including that plan's extended benefit provision) in the absence of this section.

Article 3 - Orthodontic Maximum Payment Limit

Benefits paid under the Prior Plan may be applied to the Dental Care Unit 4 Maximum Payment Limit under this Group Policy.

This policy has been updated effective January 1, 2025

Section C (3) - Replacement of Coverage under the Policyholder's Dental Health Maintenance Organization (DHMO) Plan

Article 1 - Applicability

When insurance under this Group Policy replaces a Member's or Dependent's coverage under a DHMO Plan sponsored by the Policyholder, this section will apply to those Members and Dependents who:

a. are eligible and enrolled under this Group Policy on the date of transfer from the DHMO; or

b. were covered under the DHMO on the day before the date of transfer to this Group Policy.

Article 2 - Benefits Payable

No benefits will be paid under this section for any Treatment or Service:

a. received before termination of membership in the DHMO; or

b. for which benefits are paid under the DHMO; or

c. for which benefits would have been paid under the DHMO (including that plan's extended benefit provisions) in the absence of this section.

Article 3 - Orthodontic Maximum Payment Limit

Benefits paid under the Prior Plan will be applied to the Dental Care Unit 4 Maximum Payment Limit under this Group Policy.

This policy has been updated effective January 1, 2025

Section D - Coordination with Other Benefits

Article 1 - Purpose

The intent of this section is to provide that the sum of benefits paid under this Group Policy plus benefits paid under all other Plans will not exceed the lesser of the financial liability of the Member or Dependent or the Prevailing Charge of The Principal for a Treatment or Service.

Article 2 - Definitions

As used in this section, the terms listed below will mean:

a. Plan

*Any dental expense benefits provided under:

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

The term Plan will not include benefits provided under:

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

Also, the term Plan will apply separately to those parts of any program that contain provisions for coordination of benefits with other Plans and separately to those parts of any program which do not contain such provisions.

*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 these coordination of benefits provisions. The amount payable will not be more than 100% of the actual cost charged for Treatment or Service.

b. 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.

c. 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:

(1) If a person is covered by two or more Plans that compute their benefit 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.
(2) 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.

d. Claim Determination Period

The part of a Calendar Year during which a Member or Dependent would receive benefit payments under this Group Policy if this section were not in force.

Article 3 - Effect on Benefits

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

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

b. the rules listed in Article 4 below provide that benefits payable under the other Plan are to be determined before the benefits payable under this Group Policy.

The reduction will be the amount needed to provide that the sum of payments under this Group Policy plus benefits payable under the other Plan(s) is not more than the total of Allowable Expenses. Each benefit that would be payable in the absence of this section will be reduced proportionately. Any such reduced amount will be charged against any applicable benefit limit of this Plan.

For this purpose, benefits payable under other Plans will include the benefits that would have been paid had claim been made for them. Also, 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.

Article 4 - Order of Benefit Determination

Except as described in Article 5 below, the benefits payable of a Plan that does not have a coordination of benefits provision substantially 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:

a. Nondependent/Dependent. The benefits of a Plan which covers the person for whom benefits are claimed as an employee, Member, or subscriber (that is, other than as a Dependent) are determined before the benefits of a 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:

(1) secondary to the Plan covering the person as a Dependent; and
(2) 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.

b. Dependent Child--Parents Not Separated or Divorced. Except as stated in paragraph c. below, when this Group Policy and another Plan cover the same child as a Dependent of different persons called "parents," the benefits of the Plan of the parent whose birthday falls earlier in a Calendar Year are determined before those of the Plan of the parent whose birthday falls later in that year; but if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

This policy has been updated effective January 1, 2025

However, if another Plan does not have the rule described above, but instead has a rule based on 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.

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

(1) first, the Plan of the parent with custody of the Dependent Child;
(2) then, the Plan of the spouse or registered domestic partner of the parent with custody of the Dependent Child; and
(3) 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 with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d. 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.

e. Active/Inactive Employee. The benefits of a Plan which covers the person for whom benefits are claimed as an employee who is neither laid off nor retired, or as that employee's Dependent, are determined before the benefits of a Plan which covers that person as a laid-off or retired employee or as that employee's Dependent. 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.

f. 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:

(1) first, the benefits of a Plan covering the person as an employee, Member or subscriber (or as that person's Dependent);
(2) 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.

This policy has been updated effective January 1, 2025

g. Longer/Shorter Length of Coverage. If none of the above rules determine the order of benefits, the benefits of the Plan which covered the person for whom benefits are claimed longer are determined before those of the Plan which covered that person for the shorter time.

Article 5 - Medicare Exception

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

Article 6 - Exchange of Information

Any person who claims benefits under this Group Policy must, upon request, provide all information needed to coordinate benefits as described in this section.

In addition, all information needed to coordinate benefits may be exchanged with other companies, organizations, or persons.

Article 7 - Facility of Payment

The Principal may reimburse any other Plan if:

a. benefits were paid by that other Plan; but

b. should have been paid under this Group Policy in accordance with this section.

In such instances, the reimbursement amounts will be considered benefits paid under this Group Policy and, to the extent of those amounts, will discharge The Principal from liability.

Article 8 - Right of Recovery

If, in accordance with this section, it is determined that benefits paid under this Group Policy should have been paid by any other Plan, The Principal will have the right to recover those payments from:

a. the person to or for whom the benefits were paid; and/or

b. the other companies or organizations liable for the benefit payments.

This policy has been updated effective January 1, 2025

POLICY NOTICE

California insurance law requires that each 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

For 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 the Policyholder's information only and does not become a part or condition of this Group Policy.

This policy has been updated effective January 1, 2025

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Principal Life Insurance Company
Des Moines, Iowa 50392-0002