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GROUP BOOKLET-CERTIFICATE FOR MEMBERS OF

MULTI-SERVICE CENTER

ALL MEMBERS

Group Dental Preferred Provider Organization (PPO) Insurance

Print Date: 04/06/2022

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BOOKLET-CERTIFICATE RIDER FOR
DOMESTIC PARTNERS

Effective Date: January 1, 2022

Except as specifically provided herein, this Rider is subject to all of the terms, provisions, definitions and exclusions of the booklet-certificate.

Definitions

Definition of Dependent is revised to read as follows:

Dependent means:

- Your spouse, if that spouse:
  - is not in the Armed Forces of any country; and
  - is not insured as a Member.

  Wherever the term spouse is used, this provision also includes a state registered domestic partner.
- Your Dependent Child (or Children) as defined below.
- Your Domestic Partner, if you and the Domestic Partner complete and submit a Declaration of Domestic Partnership which is approved by Us.

Definition of Dependent Child(ren) is revised to read as follows:

Dependent Child; Dependent Children means:

- Your natural or legally adopted child, if that child:
  - is not insured under the Group Policy as a Member; and
  - is less than 26 years of age.

  An adopted child will be considered a Dependent Child from the date of Placement with the Member for the purpose of adoption. Coverage will be continuous unless the Placement is disrupted prior to legal adoption and the child is removed from Placement.
- Your stepchild, if that child:
  - meets the requirements above; and
  - receives principal support from you.
- Your foster child, if that child:
  - meets the requirements above; and
  - lives with you; and
  - receives principal support from you; and
  - is under legal guardianship of you or your spouse or Domestic Partner; and
  - is approved in writing by Us as a Dependent Child.
- Your state registered domestic partner's child who otherwise qualifies above or if you or your state registered domestic partner are the child's guardian by court order.

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

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

Definition of Domestic Partner is revised to read as follows:

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

- your partner is not in the Armed Forces of any country; and
- your partner is not covered under the Group Policy as a Member; and
- your partner is at least 18 years of age; and
- neither your partner nor you are married; and
- neither your partner nor you have had another Domestic Partner in the 6-month period preceding the date of the signed Declaration of Domestic Partnership; and
- your partner is not your blood relative; and
- your partner and you have shared the same residence for at least six consecutive months and continue to do so; and
- your partner and you are each other's sole life partner and intend to remain so indefinitely; and
- your partner and you are jointly responsible for each other's financial welfare; and
- your partner and you are not in the relationship solely for the purpose of obtaining insurance coverage.

Definition of Immediate Family is revised to read as follows:

Immediate Family means an insured person's spouse, 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.

Summary of Benefits, Dental Expense Insurance is revised to read as follows:

Benefit Options

Benefit Option Transfer - Applicable only to Members already insured under the Group Policy

You may transfer from one benefit option to another:

- during the Annual Enrollment Period designated by the Policyholder for such transfer, provided you are already insured under the Group Policy; or
- On any premium due date, provided the transfer is requested due to a change in your family status as described below; and the request for the transfer is made in writing within 31 days after the date the change in family status occurs:

- marriage or divorce or establishment or termination of a state registered domestic partnership or establishment or termination of a Domestic Partner relationship;
- death of a spouse or Domestic Partner or child;
- birth or adoption of a child;
- termination of employment by your spouse or Domestic Partner or a change in the spouse's or Domestic Partner's employment that causes loss of group coverage;
- your spouse or Domestic Partner becomes employed;
- your employment or your spouse's or Domestic Partner's employment changes from part-time to full-time or from full-time to part-time;
- you or your spouse or Domestic Partner take an unpaid leave of absence; or
- your spouse's or Domestic Partner's group dental coverage involuntarily terminates.

How to be Insured, Members, the following provision is revised as follows:

Special Enrollment Period

A Special Enrollment Period, as described below, will be available for you or your Dependent if enrollment is made after the first period in which you or your Dependent are eligible to enroll. If you or your Dependent request enrollment during a Special Enrollment Period, you or your Dependent will not be considered a Late Enrollee.

The Special Enrollment Periods are:

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

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

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

  NOTE: For the purpose of (ii) above:

  "Loss of eligibility" does not include:

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

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

  (i) you are enrolled (or are eligible to be enrolled but have failed to enroll during a previous enrollment period); and
  (ii) a person becomes your Dependent through marriage, establishment of a state registered domestic partnership, or declaration of a Domestic Partner relationship, birth, adoption or Placement for Adoption; and

(iii) request for enrollment is made within 60 days after the date of the marriage, 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, if the request is made on or before the event or within 60 days after the event.

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

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

How to be Insured, Dependents, is revised by adding the following Effective Date provision:

Effective Dates.

Insurance for a Domestic Partner

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

- the date insurance would otherwise become effective for a Dependent; or

- the date We approve the Domestic Partner's status as a Dependent.

How to be Insured, Dependents, the following provision is revised as follows:

Terminations

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

- the last day of the Insurance Month in which he or she ceases to be your Dependent. However, a spouse 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.

- Your insurance under the Group Policy for a Dependent will also terminate 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.

Continuation

Continuation under any state law is available to your Domestic Partner or to your Domestic Partner's Dependent Child on the same basis as a Dependent spouse or a Dependent Child.

Note: COBRA and USERRA Continuation is not available to Domestic Partners or to a Domestic Partner's Dependent Child.

Continuation of Coverage, is revised/added as follows:

Continuation for Domestic Partners (and any Dependent Children)

(A) Qualified Persons/Qualifying Events

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

(1) an insured Domestic Partner (and any Dependent Children) following the Member's:

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

(b) a reduction in work hours.

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

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

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

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

(4) a Member's Domestic Partner (and any Dependent Children) following the Member's entitlement to Medicare.

(B) Maximum Continuation Period

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

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

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

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

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

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

C. Second Qualifying Events

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

D. Disabled Extension

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

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

E. Termination of Continued Coverage

Continued coverage ends the earliest of the following:

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

(2) the date the qualified person enrolls in Medicare; however, this does not apply to a person who is already enrolled in Medicare on the date he or she elects this group dental continuation; or

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

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

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

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

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

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

F. Employer/Plan Administrator Notification Requirement

When a covered 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.

G. Qualified Person Notice and Election Requirement

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

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

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

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

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

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

H. Monthly Cost

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

I. Grace Period

A qualified person has 45 days after the initial election to remit the first payment. The first payment must include all payments due when sent. All other payments (except for the first payment) will be timely if made within the Grace Period. "Grace Period" means the first 31-day period following a premium due date. Except for the first payment, a Grace Period of 31 days will be allowed for payment of premium. Continued coverage will remain in effect during the Grace Period provided payment is made prior to the expiration of the Grace Period. If payment is not made prior to the expiration of the Grace Period, continued coverage will terminate at the end of the last coverage period for which payment was made.

J. Policy Changes

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

K. Contact Information

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

Group Dental Plan:	MULTISERVICE CENTER Dental Plan
Contact Name/Area:	MULTISERVICE CENTER Benefits Department
Address:	1200 S. 336TH
	FEDERAL WAY WA 98003
Phone Number:	253-835-7678

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.

Facility of Payment Claim Procedures provision is revised as follows:

We will normally pay all benefits (for other than orthodontia) to you. However, if the claimed benefits result from a Dependent's dental care, We may make payment to the Dependent. Orthodontia benefits will be payable as described in Booklet-Certificate Rider for Orthodontic Treatment or Service. Also, in the special instances listed below, payment will be as indicated. All payments so made will discharge Us to the full extent of those payments.

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

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

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

Note: When benefits under the Group Policy are payable for Treatment or Services received from outside the United States, 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 providers outside the United States.

All other benefits and provisions of the Group Policy remain in effect.

See your employer if you have questions concerning this Rider.

Nothing contained in this Rider may vary, alter or extend any provision or condition of the Group Policy other than as stated in this Rider.

PRINCIPAL LIFE
INSURANCE COMPANY
Des Moines, IA 50392-0002

BOOKLET-CERTIFICATE RIDER FOR ORTHODONTIC TREATMENT OR SERVICE

MULTI-SERVICE CENTER

Effective Date: January 1, 2022

Except as specifically provided herein, this Rider is subject to all of the terms, provisions, definitions, and exclusions of the booklet-certificate.

Covered Charges will include Orthodontic Treatment or Service as listed in this Rider. The benefits payable for all listed Treatment or Service received will be 50% of Covered Charges up to a lifetime maximum benefit of $2,000 for dental care received from Preferred Providers and Non-Preferred Providers (in combination) for you or your Dependent.

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

Deductible Amount

There is no Deductible Amount.

Covered Charges used to satisfy the Orthodontic Treatment or Service Deductible Amount cannot be used to satisfy the Deductible Amount for Units 1, 2, and 3, and vice versa.

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

Orthodontia

Covered Charges will be the actual cost charged to you or your Dependent for Treatment or Service for the listed procedures described in this Rider 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.

Beginning Date for Treatment or Service

Treatment or Service will be considered to begin on the date the appliance or bands are first set.

Exclusions

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

- Orthodontic Treatment or Service, if the appliance or bands were placed prior to being insured under this Rider, unless you or your Dependent are currently in a treatment plan which was covered under prior group orthodontic coverage, and there has been no Lapse in Coverage.

Payment of Orthodontia Benefits

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

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

- 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 benefits payable:

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.

Orthodontia Treatment or Service will not be covered if the appliance or bands were placed prior to being insured under the booklet-certificate, unless:

- you or your Dependent are currently in a treatment plan which was covered under the Prior Plan; and

- there has been no Lapse in Coverage; and

- you or your Dependent submits proof that:
  - the maximum payment limit shown for orthodontia under this Rider was not exceeded under the Prior Plan; and
  - the orthodontic treatment was started and bands or appliances were inserted while insured under the Prior Plan; and
  - orthodontic treatment has been continued while you or your Dependent are insured under the booklet-certificate.

Replacement of a Prior Plan

When insurance under the Group Policy replaces coverage under a Prior Plan, this section will apply to you and your Dependents if you or your Dependents:

a. are eligible and enrolled under the Group Policy on its Date of Issue; and
b. were covered under the Prior Plan on the date of its termination.

Benefits may be payable under this section when benefits 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.

If you are not Actively at Work on the Date of Issue of the Group Policy and you 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 the Group Policy; or
b. the benefits that would have been paid by the Prior Plan had it remained in force.

If you are Actively at Work on the Date of Issue of the 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 the 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.

The maximum payment limit shown for orthodontia under this Rider will be reduced by any orthodontia benefits paid under the Prior Plan.

Definitions. As used in this Rider, the following terms will mean:

Prior Plan

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

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

Orthodontic Treatment or Service means any Treatment or Service for:

- straightening of teeth, formal, full-banded retention and treatment, including x-rays and other diagnostic procedures; and
- removable or fixed appliances for tooth or bony structure guidance or retention.

All other terms, provisions, conditions, limitations, and exclusions of the booklet-certificate remain in full force and effect with respect to benefits and all other aspects of the insurance of the booklet-certificate, and are controlling with respect to this Rider unless expressly modified herein.

Nothing in this Rider will vary, alter, or extend any provision or condition of the booklet-certificate other than as stated in this Rider.

PRINCIPAL LIFE INSURANCE COMPANY

BOOKLET-CERTIFICATE RIDER FOR DENTAL IMPLANTS

MULTI-SERVICE CENTER

Effective Date: January 1, 2022

Except as specifically provided herein, this Rider is subject to all of the terms, provisions, definitions, and exclusions of the booklet-certificate.

Covered Charges will include Treatment or Service for Dental Implants as listed in this Rider. The benefits payable for all listed Treatment or Service received will be 50% of Covered Charges up to a maximum benefit of $2,000 each Policy Year for dental care received from Preferred Providers and 50% of Covered Charges up to a maximum benefit of $2,000 each Policy Year for Non-Preferred Providers for you and your Dependent.

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

Covered Charges used to satisfy the Dental Implants maximum benefit will be used to satisfy the maximum benefit for Dental Care Units 1, 2, and 3, and vice versa.

Deductible Amount

a. Preferred Providers

If dental care is received from Preferred Providers, the individual Deductible Amount for each insured person each Policy Year will be $50 with respect to Covered Charges under the Booklet-Certificate for Dental Implants each Policy Year.

b. Non-Preferred Providers

If dental care is received from Non-Preferred Providers, the individual Deductible Amount for each insured person each Policy Year will be $50 with respect to Covered Charges under the Booklet-Certificate for Dental Implants each Policy Year.

Covered Charges used to satisfy the Dental Implants Deductible Amount will be used to satisfy the Deductible Amount for Dental Care Units 1, 2, and 3, and vice versa.

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

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

Dental Procedures

Surgical placement of implant body (endosteal, eposteal, or transosteal implant)
Implant connecting bars and supporting structures
Implant repair and removal
Implant maintenance procedure (twice per year)

Coverage for dental implants is limited to persons age 16 or over.

Initial placement of dental implants and/or supporting structures to support the replacement of teeth which were missing prior to the effective date of your or your Dependent's coverage will not be covered.

Benefits for the replacement of an existing implant are payable only if the existing implant is no longer serviceable and 60 consecutive months have elapsed since the last placement of the implant. Dental implants to replace existing fixed bridgework, partial or full denture will not be covered unless 60 consecutive months have elapsed since the last placement of the fixed bridgework, partial or full denture.

All other terms, provisions, conditions, limitations, and exclusions of the booklet-certificate remain in full force and effect with respect to benefits and all other aspects of the insurance of the booklet-certificate and are controlling with respect to this Rider unless expressly modified herein.

Nothing in this Rider will vary, alter, or extend any provision or condition of the booklet-certificate other than as stated in this Rider.

PRINCIPAL LIFE INSURANCE COMPANY

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

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

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

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

This booklet outlines what you must do to be insured. It explains how to file claims. It is your certificate while you are insured.

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

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

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

This booklet describes all the benefits available under the Group Policy underwritten by Us. If there is a conflict between the provisions of the Group Policy and the current booklet-certificate, the current booklet-certificate prevails. However, if you have elected to not accept any available benefits, those benefits described in this booklet will not apply to you.

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

If you are covered by more than one dental benefit plan, and you do not know which is your primary plan, you or your provider should contact any one of the dental plans to verify which plan is primary. The dental plan you contact is responsible for working with the other plan to determine which is primary and will let you know within 30 calendar days.

Caution: All dental plans have timely claim filing requirements. If you or your provider fail to submit your claims to a secondary dental plan within that plan's claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary dental plan, you or your provider will need to submit your claim to the secondary dental plan within its claim filing time limit to prevent a denial of the claim.

To avoid delays in claims processing, if you are covered more than one plan you should promptly report to your providers and plans any changes in your coverage.

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

PRINCIPAL LIFE INSURANCE COMPANY
Des Moines, IA 50392-0002

TABLE OF CONTENTS

SUMMARY OF BENEFITS
(revised effective January 1, 2022)

DENTAL EXPENSE INSURANCE

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

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

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

Preferred Provider Organization (PPO) Plan

Your Policyholder participates in a Preferred Provider Organization (PPO) Plan administered by Us.

As you may know, Preferred Provider Organization (PPO) Plans are arrangements whereby Dentists are contracted to furnish, at negotiated costs, dental care for the employees and their Dependents of participating Policyholders.

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

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

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

Dental Care Units

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

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

Benefits Payable

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

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

Dental benefits payable for Treatment or Services received will be:

Service	PPO Providers	Non-PPO Providers
Dental Care Unit 1		
Preventive Procedures		
Coinsurance	100%	100%
Individual Deductible	$0	$0
Family Maximum Deductible	$0	$0
Dental Care Unit 2		
Basic Procedures		
Coinsurance	90%	80%
Individual Deductible	$50 per Policy Year (Units 2 and 3 combined)	$50 per Policy Year (Units 2 and 3 combined)
Family Maximum Deductible	$150 per Policy Year (Units 2 and 3 combined)	$150 per Policy Year (Units 2 and 3 combined)
Dental Care Unit 3		
Major Procedures		
Coinsurance	50%	50%
Individual Deductible	$50 per Policy Year (Units 2 and 3 combined)	$50 per Policy Year (Units 2 and 3 combined)
Family Maximum Deductible	$150 per Policy Year (Units 2 and 3 combined)	$150 per Policy Year (Units 2 and 3 combined)

Deductible Amount(s)

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

- Covered Charges used to satisfy the Deductible that is applicable when care is received from Non-Preferred Providers will be counted toward satisfaction of the Deductible that is applicable when care is received from Preferred Providers and vice versa.

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

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

    - first, to Unit 2 charges; and

    - then, to Unit 3 charges.

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

Maximum Payment Limit

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

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

- Dental Care Units 1, 2, and 3 $2,000 each Policy Year for dental care received from Preferred Providers and $2,000 for Non-Preferred Providers (in combination).

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

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

- received at least one procedure performed during that Policy Year; and

- used $1,000 or less of benefits during the Policy Year;

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

This carry-over provision does not apply:

- during the first Policy Year for any individual having an initial coverage effective date in October, November or December; or

- until all waiting periods have been satisfied.

HOW TO BE INSURED - MEMBERS

DENTAL EXPENSE INSURANCE

Eligibility

To be eligible for insurance you must be an Employee.

If you had insurance under the Prior Policy for which this Group Policy is a replacement and are an Employee on January 1, 2022, you will be eligible on that date.

If you meet the definition of an Employee later, you will be eligible on the first of the Insurance Month following the date you complete two consecutive months of continuous Active Work.

If you elect to waive insurance because you are covered under group dental expense coverage or coverages provided by your Dependent's employer, the date such coverage terminates because your Dependent is no longer eligible under his/her employer's coverage will be considered the date you are eligible to request insurance. Termination of coverage that has been continued under any state or federal continuation provisions will not be considered as a qualifying event for the purpose of these provisions.

Effective Dates - Actively at Work

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

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

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

This Actively at Work requirement will be waived as described on the last page of this Booklet-Certificate.

Individual Incontestability and Eligibility

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

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

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

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

We may at any time terminate a person's eligibility:

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

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

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

Effective Date for Non-Contributory Insurance

Insurance for which you contribute no part of the premium will become effective on the date you are eligible, unless you request to waive coverage and are covered under another group dental expense coverage. You must request insurance on a form approved by Us.

Effective Date for Contributory Insurance

If you are required to contribute towards the cost of insurance, you must request insurance in a form approved by Us.

If the request is made on or before the date you are eligible or within 31 days after you are eligible, the requested insurance will become effective on the first of the Insurance Month following the date you are eligible.

If the request is made more than 31 days after the date you are eligible and other than during the Annual Enrollment Period or Special Enrollment Period described below, the requested insurance will become effective as described for Late Entrants.

If request for contributory insurance is made more than 31 days after the date you are eligible but during the Annual Enrollment Period described below, insurance will become effective as described under Annual Enrollment Period.

If request for contributory insurance is made more than 31 days after the date you are eligible but as a result of a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) described below, insurance will become effective as described under Court Ordered Coverage below.

If request for contributory insurance is made more than 31 days after the date you are eligible but during a Special Enrollment Period, insurance will become effective as described below under Special Enrollment Period.

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

Late Enrollment Provisions

- Definition

  Late Enrollee. Late Enrollee means a Member or Dependent who failed to enroll:

  (i) during the first period in which he or she was eligible to enroll, or during any subsequent Special Enrollment Period as described below; or
  (ii) within 31 days after the termination date, if the individual was previously insured but elected to terminate such insurance.

  For the purposes of (i) above, only the most recent period of eligibility will be considered in determining whether an individual is a Late Enrollee if the individual loses eligibility and the individual later becomes eligible again.

The term "Late Enrollee" also means a Member or Dependent who does not qualify for one of the Special Enrollment Periods as described below.

- Effective Date for Late Enrollees

  If a Late Enrollee requests insurance other than during an Annual Enrollment Period or Special Enrollment Period, the effective date of insurance for such Late Enrollee will be the next Policy Anniversary date, provided on such date:

  (i) the Member continues to meet the definition of Member; and
  (ii) for Dependent Dental Expense Insurance, the Dependent continues to meet the definition of Dependent.

Annual Enrollment Period

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

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

- during any previous Annual Enrollment Period; or

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

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

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

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

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

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

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

- you are enrolled (or eligible to be enrolled but have failed to enroll during a previous enrollment period); and

- you failed to enroll your Dependent Child during a previous enrollment period; and

- you are required by a QMCSO or NMSN as defined by applicable federal law and state insurance laws to provide dental coverage to your Dependent Child.

The request for enrollment:

- may be made at any time after the issue date of the QMCSO or NMSN; and

- will apply only to you and/or your Dependent Child(ren) listed in the QMCSO or NMSN.

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

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

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

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

Special Enrollment Period

A Special Enrollment Period, as described below, will be available for you or your Dependent if enrollment is made after the first period in which you or your Dependent are eligible to enroll. If you or your Dependent request enrollment during a Special Enrollment Period, you or your Dependent will not be considered a Late Enrollee.

The Special Enrollment Periods are:

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

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

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

  NOTE: For the purpose of (ii) above:

  "Loss of eligibility" does not include:

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

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

  (i) you are enrolled (or are eligible to be enrolled but have failed to enroll during a previous enrollment period); and
  (ii) a person becomes your Dependent through marriage, state registered domestic partnership, birth, adoption or Placement for Adoption; and
  (iii) request for enrollment is made within 60 days after the date of the marriage, state registered domestic partnership, birth, adoption or Placement for Adoption, or the date Dependent Dental Expense Insurance is available to the Member, if the request is made on or before the event or within 60 days after the event.

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

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

Effective Date for Benefit Changes Due to a Change in Insurance Class

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

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

Any termination of your Scheduled Benefits amount because of a change in your status (insurance class) will be effective on the date of the change in status, whether or not you are Actively at Work.

Effective Date for Benefit Changes Due to a Change by Policy Amendment

A change in your Scheduled Benefit amount because of a change in benefits elected by the Policyholder will be effective on the first of the Insurance Month following the date of the change.

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

Termination

Unless continued as provided below your insurance will cease on the earliest of:

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

Continuation

If you cease Active Work because of sickness or injury, you may be eligible for limited continuation of insurance. See the continuation provisions described in the Continuation of Coverage section of this Booklet-Certificate.

If you cease Active Work because of layoff or leave of absence, insurance may be continued on a limited basis. See the continuation provisions described in the Continuation of Coverage section of this Booklet-Certificate.

In addition, by paying the required contribution, if any, your insurance may be continued under the continuation provisions described in this Booklet-Certificate.

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

Reinstatement

Your terminated insurance will be reinstated if:

- insurance ceased because of layoff or approved leave of absence; and
- you return to Active Work for the Policyholder within six months of the date insurance ceased.

Your reinstated insurance will be in force on the first of the Insurance Month following the date of return to Active Work. However, the Actively at Work provision described above will apply.

Only the period of time during which you are actually insured will be included in determining the length of your continuous coverage. For this purpose the period of time during which your reinstated insurance was not in force:

- will not be considered an interruption of continuous coverage; and
- will not be used to satisfy any provision 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 parental leave.

Insurance While Outside of the United States

If you or your Dependent are temporarily outside the United States, you or your Dependent may choose to continue insurance, subject to premium payment for one of the following reason:

- travel; or
- a business assignment; or
- full-time student status, provided the student is either;
- enrolled and attending an accredited school in a foreign country; or
- 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.

If you or your Dependent are outside the United States for any other reason than those listed above, their coverage will automatically terminate.

HOW TO BE INSURED - DEPENDENTS

DENTAL EXPENSE INSURANCE

Eligibility

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

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

If your Dependent is employed and is covered under group dental expense coverage or coverages provided by your Dependent's employer, the date such coverage is terminated because your Dependent is no longer eligible under his/her employer's coverage will be considered the date you first acquire that Dependent (and any other Dependent who was also covered under such group coverage or coverages). Termination of coverage that has been continued under any state or federal continuation provisions will not be considered as a qualifying event for the purpose of these provisions.

Effective Date

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

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

Insurance for a Newborn or Newly Adopted Child

A newly born or newly adopted Dependent Child will be insured for dental expense benefits from the moment of birth, or on the date of adoption or placement for adoption (whichever is earlier), provided the child meets the definition of a Dependent Child.

However, if you are required to contribute toward the cost of Dependent insurance, you must notify Us within 60 days after the date of birth or placement for adoption, in order to continue the child's insurance beyond the 60-day period following the child's date of birth or placement for adoption. If such notice is not given to Us within the 60-day period, the child's insurance will terminate. If the request for enrollment is a result of a QMCSO or NMSN, the child is eligible for Court-Ordered Coverage as described in the How To Be Insured - Members section of this Booklet-Certificate.

If the child's insurance terminates because you fail to request coverage (or pay the required contribution) within the 60-day period after the date of birth or placement for adoption, benefits will be payable only for covered expenses incurred by the child during the 60-day period which insurance was in force.

Individual Incontestability and Eligibility

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

Termination

Unless continued as provided below, insurance for all of your Dependents will terminate on the earlier of:

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

- the end of the Insurance Month for which the last contribution is made for your Dependent's insurance; or

- for contributory insurance, the end of any Insurance Month, if requested by you before that date; or

- the date your Member insurance ceases.

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

Developmentally Disabled or Physically Handicapped Children

Dental Expense Insurance for a child may be continued after the child reaches the maximum age for Dependent Children as defined, 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 you for primary support; and

- except for age, the child continues to be a Dependent Child as defined; and

- proof of the child's incapacity is sent to Us within 31 days after the date the child reaches the maximum age; and

- further proof that the child remains incapable of self-support is provided when We request, but not more often than once a year after the initial two-year period after reaching the maximum age.

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

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

Continuation

In addition, under certain conditions, your Dependent's Dental Expense Insurance may be continued after the date it would normally terminate. See the continuation provisions described in this Booklet-Certificate.

Sickness or Injury

If Active Work ends because you are sick or injured, your insurance may be continued until the earliest of:

- the date the Group Policy terminates; or
- the end of the Insurance Month for which the last premium is paid for your insurance; or
- for contributory insurance, the end of any Insurance Month, if requested by you before that date; or
- the end of the Insurance Month in which you cease to be in a class for which Member Dental Expense Insurance is provided; or
- the end of the Insurance Month in which you recover; or
- the end of the Insurance Month in which you are covered under the USERRA continuation provision; or
- the end of the Insurance Month after coverage has been continued for 12 consecutive months.

If coverage 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.

Layoff or Approved Leave of Absence

If Active Work ends because you are on layoff or approved leave of absence, your insurance may be continued until the earliest of:

- the date the Group Policy terminates; or
- the end of the Insurance Month for which the last premium is paid for your insurance; or
- for contributory insurance, the end of any Insurance Month, if requested by you before that date; or
- the end of the Insurance Month in which you cease to be in a class for which Member Dental Expense Insurance is provided; or
- the end of the Insurance Month in which the layoff or approved leave of absence ends; or
- the date you become eligible for any other group dental expense coverage; or
- 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 parental leave.

If coverage 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.

State Required Continuation - Washington

If you end Active Work because of a strike, lockout, or other labor dispute, your insurance may be continued during the dispute, if:

- the Group Policy is in force; and
- you elect to continue coverage and agree to pay the required premium; and
- We receive information needed to administer the Group Policy.

Insurance for you, if you qualify as set forth above, may be continued until the earliest of:

- the date insurance has been continued for six months; or
- the date you request that your insurance be terminated; or
- the date you fail to pay any required premium; or
- the date you become eligible for other group dental expense coverage; or
- the date the Group Policy terminates.

The Policyholder must notify you by mail that insurance may be continued by paying the required premium.

No change may be made to the Group Policy during the six month period and while the Group Policy is in force. However, We may change the premium rate in force, as allowed by Washington regulations, with respect to these continuation provisions.

COBRA CONTINUATION

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

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

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

A. Qualified Persons/Qualifying Events

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

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

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

(ii) a reduction in work hours.

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

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

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

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

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

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

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

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

B. Maximum Continuation Period

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

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

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

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

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

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

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

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

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

C. Second Qualifying Events

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

D. Disabled Extension

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

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

E. Termination of Continued Coverage

Continued coverage ends the earliest of the following:

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

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

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

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

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

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

F. Employer/Plan Administrator Notification Requirement

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

G. Qualified Person Notice and Election Requirement

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

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

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

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

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

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

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

H. Monthly Cost

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

I. Grace Period

Qualified persons have 45 days after the initial election to remit the first payment. The first payment must include all payments due when sent. All other payments (except for the first payment) will be timely if made within the Grace Period. "Grace Period" means the first 31-day period following a premium due date. Except for the first payment, a Grace Period of 31 days will be allowed for payment of premium. Continued coverage will remain in effect during the Grace Period provided payment is made prior to the expiration of the Grace Period. If payment is not made prior to the expiration of the Grace Period, continued coverage will terminate at the end of the last coverage period for which payment was made.

J. Policy Changes

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

K. Newly Acquired Dependents

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

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

L. Contact Information

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

Group Dental Plan:	MULTISERVICE CENTER Dental Plan
Contact Name/Area:	MULTISERVICE CENTER Benefits Department
Address:	1200 S. 336TH FEDERAL WAY WA 98003
Phone Number:	253-835-7678

FEDERAL FAMILY AND MEDICAL LEAVE ACT (FMLA)

Continuation

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

This is a general summary of the FMLA. Additional information about FMLA is available from your employer.

FMLA and Other Continuation Provisions

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

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

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

Eligible Employer

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

Eligible Employee

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

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

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

Mandated Unpaid Leave

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

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

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

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

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

Reinstatement

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

Additional information is available from your employer.

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

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

Continuation

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

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

The continuation provision will be in addition to any other continuation provisions for sickness, injury, layoff, or approved leave of absence, if any. These continuation provisions, however, will terminate on the end of the Insurance Month in which you are covered under the USERRA continuation provision. If you qualify for both state and USERRA continuation, the election of one means the rejection of the other.

Reinstatement

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

This is a general summary of the USERRA. Additional information about USERRA is available from your employer.

DESCRIPTION OF BENEFITS

DENTAL EXPENSE INSURANCE
(PAYMENT PROVISIONS)

Benefit Qualification

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

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

Benefits Payable

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

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

Benefits Payable - State Required - Washington

Subject to the benefits payable provisions as described above, benefits will be payable for:

- **Denturist**

  Covered Charges will include charges for any service performed by a licensed Denturist if:

  - the service performed was within the lawful scope of such person's license; and
  - benefits would have been provided if such service had been performed by a Dentist.

- **Coverage for Temporomandibular Joint Disorders**

  Covered Charges will include charges for Dental Services incurred for treatment of Temporomandibular Joint Disorders.

  Benefits will be payable to a calendar year maximum of $1,000, and a lifetime maximum of $5,000 for you or your Dependent.

  "Temporomandibular Joint Disorders" means those disorders which have one or more of the following characteristics:

  - pain in the musculature associated with the temporomandibular joint; or
  - internal derangements of the temporomandibular joint; or
  - arthritic problems with the temporomandibular joint; or
  - an abnormal range of motion or limitation of motion of the temporomandibular joint.

  "Dental Services" mean those services which are:

- reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case; and

- effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: pain, infection, disease, difficulty in speaking or difficulty of chewing or swallowing food; and

- recognized as effective, according to the professional standards of good dental practice; and

- not experimental or primarily for cosmetic purposes.

- **General Anesthesia**

Covered Charges will include charges for the administration of medically necessary General Anesthesia Services in conjunction with any covered dental procedure performed in a dental office if the General Anesthesia Services are medically necessary because the covered person is:

- under the age of seven; or

- physically or developmentally disabled.

The administration of General Anesthesia Services must be administered by a Dentist for dental procedures performed in a Dentist's office.

General Anesthesia Services means services to induce a state of unconsciousness accompanied by a loss of protective reflexes, including the ability to maintain an airway independently and respond purposefully to physical stimulation or verbal command.

DENTAL EXPENSE INSURANCE

BENEFIT PROVISIONS

Payment Conditions

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

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

as described in the SUMMARY OF BENEFITS Section.

Covered Charges

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

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

Beginning Date for Treatment or Service

Treatment or service will be considered to begin:

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

Completion Date for Treatment or Service

Treatment or Service will be considered to be completed:

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

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

DENTAL EXPENSE INSURANCE –EXCLUSIONS

Exclusions

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

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

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

- Treatment or Service which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three years; or

- Treatment or Service that is an Experimental or Investigational Measure. (The denial of any claim on the basis of the exclusion of coverage for experimental or investigational Treatment or Service may be appealed through the procedure described in the notice of that claim decision); or

- Treatment or Service that is paid by a Medicare Supplement Insurance Plan; or

- Treatment or Service for temporomandibular joint disorders, except as provided under the Temporomandibular Joint Disorders provision described in the Dental Expense Insurance section of this Booklet-Certificate under Benefits Payable - State Required - Washington; or

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

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

- Treatment or Service for patient management (including but not limited to nitrous oxide and analgesia), local anesthetic and general anesthesia and IV sedation, except as provided under the General Anesthesia provision described in the Dental Expense Insurance section of this Booklet-Certificate under Benefits Payable - State Required - Washington; or

- Occlusal guards, except as provided under Temporomandibular Joint Disorders provision described in the Dental Expense Insurance section of this Booklet-Certificate under Benefits Payable - State Required - Washington; or

- charges that are billed incorrectly or separately for Treatment or Services that are an integral part of another billed Treatment or Service as determined by Us.

SCHEDULE OF DENTAL PROCEDURES - UNIT 1

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

Dental Care Unit 1 - Preventive Procedures

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

Dental Procedure

Examinations

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

Oral examination (evaluation)

Periodic 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. Covered once in any Policy Year.

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

Radiographs

Full Mouth Survey

Complete series (including bitewings)
Panoramic

Only one of the listed full mouth surveys will be covered in any 36 consecutive month period.

Bitewing

Only two sets will be covered in any Policy Year.

Occlusal

Only two films will be covered in any Policy Year.

Periapical

Only four films will be covered in any Policy 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. These x-rays will be considered part of the underlying treatment charge.

Preventive Services

Prophylaxis (cleaning of teeth)

Limited to two dental prophylaxis in any Policy 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 19. Only one application(s) will be covered in any Policy Year.

Topical application of sealants

Applicable only to first and second permanent molars for Dependent Children under age 19. Covered once each tooth in any 36 consecutive month period.

Other Services

Space maintainers

Applicable only to Dependent Children under age 19. Repairs to space maintainers are not covered. Limited to one bilateral space maintainer per arch or one unilateral space maintainer per quadrant.

SCHEDULE OF DENTAL PROCEDURES - UNIT 2

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

Dental Care Unit 2 - Basic Procedures

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

Dental Procedure

Restorations

Fillings (amalgam or resin-based composite)

Anterior

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

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

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

Posterior

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

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

Replacement

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

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. If a permanent crown replaces a crown listed in this section at a later date but before replacement restrictions allow, all new charges will be reduced by those already paid.

Endodontic Services

Vital pulpotomy

> Covered for deciduous teeth only.

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

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

Periodontic Services

Scaling and root planing (each quadrant)

Covered once each quadrant in any 24 consecutive month period.

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

Full Mouth Debridement

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

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

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

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

Periodontal Surgical Procedures

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

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

Bone Replacement Graft

Covered once per site per lifetime.

Oral Surgery

Simple extraction
Surgical removal of erupted tooth

Root removal - exposed roots

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

Incision and drainage of dental abscess
Biopsy of soft tissue

Other Oral Surgical Procedures

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

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

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

Anesthesia

General anesthesia
IV sedation

General anesthesia or IV sedation is payable for the following covered services when performed in 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 7, periodontal osseous surgery, bone grafting, surgical removal of four third molars on the same date of service.

NOTE: See General Anesthesia provision under Benefits Payable - State Required - Washington in the Dental Expense Insurance section of this Booklet-Certificate for additional information.

Other Services

Emergency Examination (evaluation)

Coverage for Emergency Examination is covered under Unit 1. Other Examinations are covered under Unit 1. However, the Emergency Examination and Examination limit is combined.

Consultation with specialist

Covered once in any 12 consecutive month period. A consultation with a specialist will be covered if no other services are performed (other than x-rays) during the visit. If other services are performed during the visit, they will be considered separately.

Antibiotic drug injection

Office visit after regularly scheduled hours

An office visit after regularly scheduled hours will be covered if no other services are performed (other than x-rays) during the visit. If other services are performed during the visit, they will be considered separately.

Palliative treatment

Recementing

Inlay
Onlay
Crown
Bridgework

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

Repairs to complete or partial denture, bridge, or crown

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

Relining or rebasing complete or partial dentures

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

Tissue Conditioning

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

Denture Adjustment

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

Harmful Habit Appliance

Limited to one time per person under age 19.

SCHEDULE OF DENTAL PROCEDURES - UNIT 3

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

Dental Care Unit 3 - Major Procedures

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

Dental Procedure

Restorations

Inlays and onlays

Inlay or onlay restorations are covered only if the tooth cannot be restored by a filling and (for replacements) at least 60 consecutive months have elapsed since the last placement.

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

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

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

Crowns (single restorations only)

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

Crowns are covered only if the tooth cannot be restored by a filling and (for replacements) at least 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. Crowning of implant replacing a tooth missing prior to the effective date is not covered. For persons under 16 years of age, the benefit for crown on vital teeth is limited to prefabricated resin or stainless steel crowns. Crowning of implant replacing a pontic will not be covered unless at least 60 consecutive months have elapsed since placement of the pontic. The date the crown is cemented in the mouth will be used in determining benefits payable.

Cast post and core

Covered only for teeth that have had root canal therapy. Covered once per tooth per 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

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.

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

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.

Bridgework to replace a partial denture will be covered only if at least 60 consecutive months have elapsed since the last placement of the partial denture.

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

Prosthodontics, Removable

Complete or partial dentures - initial placement or replacement

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

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.

DENTAL EXPENSE INSURANCE

EXTENDED BENEFITS - INDIVIDUAL TERMINATIONS
(after termination of insurance)

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

- root canal therapy, but only if the pulp chamber was opened and the pulp canal explored to the apex while you or a Dependent were insured; and

- crowns, bridges, inlays, or onlay restorations, but only if the tooth or teeth were fully prepared while you or a Dependent were insured; and

- complete or partial dentures, but only if the master impression was made while you or a Dependent were insured;

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

You or a Dependent will qualify if:

- you or a Dependent would have qualified for benefit payment had insurance remained in force; and

- the Treatment or Service began while you or a Dependent were insured; and

- the Group Policy is in force at the time Treatment or Service is received.

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

DENTAL EXPENSE INSURANCE

COORDINATION WITH OTHER BENEFITS

Applicability

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

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

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

- may be reduced when, under the order of benefits determination rules, another plan determines its benefits first.

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

Definitions

"Plan" is any of these which provides benefits or services for, or because of, medical or dental care or treatment.

- group, individual or blanket disability insurance contracts; and
- group or individual contracts issued by health care service contractors or health maintenance organizations (HMO); and
- closed panel plans or other forms of group coverage; and
- the medical components of long term care contracts, such as skilled nursing care; and
- Medicare or other governmental benefits, except as provided below.

The term Plan will not include coverage provided under:

- hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; or
- accident only coverage or
- specified disease or specified accident coverage; or
- limited benefit health coverage, as defined by state law; or
- school accident-type coverage; or
- benefits for nonmedical components of long-term care policies; or
- automobile insurance policies required by statute to provide medical benefits; or
- Medicare supplement policies; or
- Medicaid coverage; or
- coverage under other federal governmental plans, unless permitted by law.

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.

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

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

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

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

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

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

Effect on Benefits

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

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

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

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

For this purpose:

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

- for any person covered by Medicare Part A, benefits payable will include benefits provided by Medicare Part B only if the person is covered under that Part B.

Order of Benefit Determination

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

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

- **Non-Dependent/Dependent.** The plan which covers the person as an employee, member, or subscriber (that is, other than as a Dependent) is determined before those of the plan which covers the person as a Dependent.

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

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

  - first, the Plan of the parent with custody of the Dependent Child;
  - second, the Plan of the spouse of the parent with custody of the Dependent Child; and
  - third, the Plan of the parent not having custody of the Dependent Child; and
  - finally, the Plan of the spouse of the parent not having custody of the Dependent Child.

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

- **Dependent Child - Individuals who are not the parents of the Dependent Child.** For a Dependent Child covered under more than one Plan of individuals who are not the parents of the Dependent Child, the Plans covering the Dependent Child will follow the order of benefit determination rules for Dependent Children of parents who are not separated or divorced.

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

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

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

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

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

If none of the preceding rules determines the order of benefits, the allowable expenses must be shared equally between the plans.

Medicare Exception

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

Federal law will usually apply in such instances if:

- the benefits are applicable to an active (rather than a retired) Member or to that Member's spouse; and
- the Member's employer has 20 or more employees.

How COB Works

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

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

1. Company A would be Primary (mother's carrier).
2. Company B would be Secondary (stepfather's carrier).
3. We would then determine the benefits payable, if any, under this Plan.

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

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

Company A

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

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

Company B

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

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

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

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

Company A

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

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

Company B

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

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

CLAIM PROCEDURES

Notice of Claim

Written notice of claim must be given to Us within 20 calendar days after the date of loss. Notice given by or provided on behalf of you or your Dependent to any authorized agent of Principal Life with information sufficient to identify you or your Dependent will be deemed notice to Us. Failure to provide notice on time may result in invalidation or reduction of your claim. For more information you or your Dependent may call the number on the back of your I.D. card.

Claim Forms

Except in the case of dental care received from PPO Providers, Claim forms and other information needed to prove loss must be filed with Us in order to obtain payment of benefits. The Policyholder will provide forms to assist you in filing claims. If the forms are not provided within 15 calendar days after We receive such notice of claim, you will be considered to have complied with the requirements regarding proof of loss upon submitting, within the time specified below for filing proof of loss, written proof covering the occurrence, character and extent of the loss.

Proof of Loss

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

Failure to furnish such proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within such time; provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the date proof is otherwise required.

Payment, Denial, and Review

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

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

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

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

Preferred Providers

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

Dental Treatment Plan

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

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

Facility of Payment

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

- If payment amounts remain due upon your death, those amounts may, at Our option, be paid to your estate, spouse, child, or parent, or a provider of dental services.

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

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

Note: When benefits are payable for Treatment or Services received from outside the United States, 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 providers outside the United States.

Recoding of Procedures

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

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

Dental Examinations

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

Legal Action

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

Time Limits

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

STATEMENT OF RIGHTS

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

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

ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan

fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

SUPPLEMENT TO YOUR BOOKLET-CERTIFICATE

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

1. **Employer Plan Identification Number:**

   EIN: 23-7120815

2. **Type of Administration:**

   Dental Insurance Contract.

3. **Plan Administrator:**

   MULTI-SERVICE CENTER
   1200 S. 336TH
   FEDERAL WAY WA 98003

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

4. **Plan Sponsor:**

   MULTI-SERVICE CENTER
   1200 S. 336TH
   FEDERAL WAY WA 98003

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

   MULTI-SERVICE CENTER
   1200 S. 336TH
   FEDERAL WAY WA 98003
   (253)835-7678

   Legal process may also be served upon the plan administrator.

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

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

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

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

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

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

December 31

DEFINITIONS

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

Accidental Injury means an injury to the natural teeth that results solely from accidental means. Not included is any injury that results from chewing.

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

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

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

- necessary and appropriate;
- Generally Accepted.

Date of Issue means the date the Group Policy is placed in force: January 1, 2022.

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

Dental Charges Database (DCD) means a commercially available dental charge information database selected by Us that provides historical information about the charges of dental care providers by procedure code and geographic categories, all as determined and adjusted by the database supplier. The Dental Charges Database will be updated by Us as information becomes available from the database supplier, up to twice each year. We may also modify the database at our discretion to reflect our own experience. We have discretion to substitute or replace the selected database with a database or databases of comparable purpose, including a database using information of Ours only, as determined and adjusted by Us, with or without notice. When there is minimal data available, as determined by Us, from the DCD for a Treatment or Service, We will determine the Prevailing Charge by calculating the unit cost for the applicable Treatment or Service category using the DCD and multiplying by the relative value of the Treatment or Service based upon a relative value scale selected by Us. When considering a complex Treatment or Service or a Treatment or Service that is a new procedure or otherwise does not have a relative value that is applicable, We will assign one. The determination of the Prevailing Charge does not take into account the Non-Preferred Provider’s training, experience or category of licensure.

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

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

- is in writing; and
- lists the procedures required for the Period of Dental Treatment; and
- shows the charges for each procedure; and
- is accompanied by any diagnostic materials that We might request.

Dentist means:

- a person licensed to practice dentistry; and

- a licensed Physician who provides dental Treatment or Service.

Denturist means a person licensed under state law to engage in the practice of denturism.

The practice of denturism means:

- making, placing, constructing, altering, reproducing, or repairing a denture; and

- taking impressions and furnishing or supplying a denture directly to a person or advising the use of a denture, and maintaining a facility for the same.

Dependent means:

- your spouse, if your spouse:

  - is legally married to the Member; and
  - is not in the Armed Forces of any country; and
  - is not insured under the Group Policy as a Member.

  Your spouse will also include a state registered domestic partner.

- your Dependent Child (or Children) as defined below.

Dependent Child; Dependent Children means:

- Your natural or legally adopted child, if that child:

  - is not insured under the Group Policy as a Member; and
  - is less than 26 years of age.

  An adopted child will be considered a Dependent Child from the date of Placement with you for the purpose of adoption. Coverage will be continuous unless the Placement is disrupted prior to legal adoption and the child is removed from Placement.

- Your stepchild, if that child:

  - meets the requirements above; and
  - receives principal support from you.

- Your foster child, if that child:

  - meets the requirements above; and
  - lives with you; and
  - receives principal support from you; and
  - is under legal guardianship of you or your spouse; and
  - is approved in writing by Us as a Dependent Child.

- Your state registered domestic partner's child who otherwise qualifies above or if you or your state registered domestic partner are the child's guardian by court order.

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

Developmental Disability means a Dependent Child's substantial handicap, as determined by Us, which:

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

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

Emergency Treatment means any Treatment or Service for an emergency dental condition manifesting itself by acute symptoms of sufficient severity, including severe pain or infection such that a prudent layperson, who possesses an average knowledge of health and dentistry, could reasonably expect the absence of immediate dental attention to result in:

- placing the health of the individual, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy;

- serious impairment to bodily functions; or

- serious dysfunction of any bodily organ or part.

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

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

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

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

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

- has been accepted as the standard of practice according to the prevailing opinion among experts as shown by (or in) articles published in authoritative, peer-reviewed dental and scientific literature; and

- is in general use in the relevant dental community; and

- is not under scientific testing or research.

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

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

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

Insurance Month means calendar month.

Member means an Employee of the Policyholder who is insured under the Group Policy.

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

Non-Preferred Provider/Non-PPO Provider means a Dentist not contracted with The Principal Plan Dental Network.

Orthodontic Treatment or Service means any Treatment or Service for:

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

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

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

Physical Handicap means a Dependent Child's substantial physical or mental impairment, as determined by Us, which:

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

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

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

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

Policy Anniversary means January 1, 2023 and the same day of each following year.

Policy Year means Calendar Year.

Policyholder means MULTI-SERVICE CENTER.

Preferred Provider/PPO Provider means a Dentist contracted within The Principal Plan Dental Network.

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

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

Preferred Provider Organization (PPO) means The Principal Plan Dental Network.

Prevailing Charges means:

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

- For dental care received from Non-Preferred Providers, the actual cost charged, but only to the extent that the actual cost charged does not exceed the 95% percentile identified on the Dental Charges Database (DCD). Non-Preferred Providers may charge you or your Dependent the difference between the actual cost charged and the Prevailing Charge.

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

Second Opinion Consultation Charges means Covered Charges for:

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

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

Second Opinion Physician means a Physician or Dentist who is:

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

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

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

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

REPLACEMENT OF A PRIOR PLAN

When insurance under the Group Policy replaces coverage under a Prior Plan, this section will apply to you and your Dependents if you or your Dependents:

- are eligible and enrolled under the Group Policy on its Date of Issue; and
- were covered under the Prior Plan on the date of its termination.

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

- benefits would have been paid under the Prior Plan had it remained in force; and
- benefits are not paid under the Prior Plan due to its termination.

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

- the benefits of the Group Policy; or
- the benefits that would have been paid by the Prior Plan had it remained in force.

If you are Actively at Work on the Date of Issue of the 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:

- received before the Date of Issue of the Group Policy; or
- for which benefits are paid under the Prior Plan; or
- for which benefits would have been paid under the Prior Plan (including that plan's extended benefit provision) in the absence of this section.

Deductible Credit

Charges for Treatment or Service received by you or your Dependent while covered under a Prior Plan may be applied to satisfy the Dental Care Units 2 and 3 Deductible Amount(s) for the Policy Year in which the Group Policy became effective, provided the charges are limited to those that:

- would be Covered Charges under Dental Care Units 2 and 3; and
- were not paid under the Prior Plan; and
- were for Treatment or Service received during the Policy Year in which the Group Policy became effective; and
- would have counted toward satisfaction of the Prior Plan's Deductible Amount.

Notice of Privacy Practices for Health Information

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

This Notice of Privacy Practices describes the practices of Principal Life Insurance Company for safeguarding individually identifiable health information. The terms of this Notice apply to members, their spouses and dependents for their group dental expense, group vision care expense and/or group critical illness insurance with us ("insurance"). As used in this Notice, the term "health information" means information about you that we create, receive or maintain in connection with your insurance; that relates to your physical or mental condition or payment for health care provided to you; and that can reasonably be used to identify you. This Notice was effective April 14, 2003 and revisions to this Notice are effective May 15, 2019.

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

Uses and Disclosures of Your Health Information

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

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

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

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

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

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

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

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

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

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

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

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

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

Your Rights

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

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

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

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

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

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

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

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

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Principal Life Insurance Company
Des Moines, Iowa 50392-0002