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**GROUP BOOKLET-CERTIFICATE FOR MEMBERS OF**

# **EVANGELICAL PRESBYTERIAN CHURCH**

**MEMBERS ELECTING LOW DENTAL PLAN**

**Group Dental Preferred Provider Organization (PPO) Insurance**

**Print Date: 11/04/2016**

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

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

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

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

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

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

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

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

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

PRINCIPAL LIFE  
INSURANCE COMPANY  
Des Moines, IA 50392-0001

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**SUMMARY OF BENEFITS**  
**(effective January 1, 2017)**

**DENTAL EXPENSE INSURANCE**

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

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

<b>Class</b>	<b>Scheduled Benefit</b>
Members and their Dependents	All benefits for Covered Charges under Dental Care Units 1 and 2.

However, benefits for Covered Charges under Dental Care Unit 2 will be limited if you or if any of your Dependents become insured under the Benefit Waiting Period provision described on page GH 1107.

**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](http://www.principal.com), you can review preferred provider directories for your PPO Network. Click on "Provider Directory," then "Search for a Dental Provider," then you can continue to follow the prompts to find your PPO network. If you do not have Internet access, you can request a paper copy of the provider directory for your PPO network from (800) 554-3392 for dental providers. Whether using the Internet or a paper directory, we recommend that you (1) verify your provider's participation in the network before seeking treatment and (2) confirm 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
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**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:

<b>Service</b>	<b>PPO Providers</b>	<b>Non-PPO Providers</b>
<u>Dental Care Unit 1</u>		
Preventive Procedures		
Coinsurance	100%	100%
Individual Deductible	None	None
Family Maximum Deductible	None	None

Dental Care Unit 2

Basic Procedures		
Coinsurance	80%	80%
Individual Deductible	\$25 per Calendar Year	\$25 per Calendar Year
Family Maximum Deductible	\$75 per Calendar Year	\$75 per Calendar Year

**Deductible Amount(s)**

- You pay an individual Deductible Amount for each insured person for dental Treatment or Service received under each Dental Care Unit for a Calendar Year. The individual Deductible Amount will be the amount shown above. After you satisfy the Deductibles, We will pay Covered Charges at the rate indicated for each Dental Care Unit.
- For each Dental Care Unit, Covered Charges used to satisfy the Deductible that is applicable when care is received from Non-Preferred Providers for the Calendar Year will be counted toward satisfaction of the Deductible that is applicable when care is received from Preferred Providers for the Calendar Year, 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 for the Calendar Year.
- In place of individual Deductibles, a family maximum Deductible may be applied. When this family maximum is satisfied for a Calendar Year, Dental benefits will be payable as if the individual Deductibles had been satisfied for each person in your family. The family maximum Deductible each Calendar Year will be the amount shown above (but not counting more than the individual Calendar Year Deductible Amount for any one person in your family).

### **Emergency Treatment**

If you or one of your Dependents require Treatment or Service for Emergency Treatment, either within the PPO Service Area or outside the PPO Service Area, and cannot reasonably reach a Preferred Provider, benefits for such Treatment or Service received will be paid as if a Preferred Provider had provided the Treatment or Service.

### **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 Unit 2 \$500 each Calendar Year for dental care received from Preferred Providers and \$500 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.

### **Benefit Advice**

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

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

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

### **Benefit Options**

- **Benefit Option Election**

You may elect to be insured under any of the benefit options offered by the Policyholder.

If you elect coverage under the benefit option described in this booklet, you will have free choice of providers. However, benefits payable will be reduced if dental care is not received from a Preferred Provider.

The benefit option elected by you will also apply to your Dependents.

Contact your employer to see what other benefit options may be available.

If you elect to waive coverage under the Group Policy, you will be eligible to apply for coverage under one of the benefit options during the next Annual Enrollment Period as described on GH 1103. If you waive coverage under the Group Policy, coverage is also waived for your Dependents. In no event will Dependent Dental Expense Insurance be in force for a Member who is not insured for Member Dental Expense Insurance.

Other than during a Special Enrollment Period, the Benefit Waiting Period provisions described on GH 1107, will apply to you and/or your Dependent who has previously waived or terminated coverage under the Group Policy if you and/or your Dependent again request to be insured under the Group Policy during an Annual Enrollment Period as described on GH 1103.

- **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;
  - death of a spouse or child;
  - birth or adoption of a child;
  - termination of employment by your spouse or a change in the spouse's employment that causes loss of group coverage;
  - your spouse becomes employed;
  - your employment or your spouse's employment changes from part-time to full-time or from full-time to part-time;
  - you or your spouse takes an unpaid leave of absence; or
  - your spouse's group dental coverage involuntarily terminates.

Any benefit option transfer will be subject to the following provisions:

- Charges for Treatment or Service received by you or your Dependent while insured under one benefit option may be applied toward satisfaction of the Calendar Year Deductible and maximum payment limit under the other benefit option for the Calendar Year in which the transfer occurs, provided the charges are limited to those that:
  - would be Covered Charges under the Group Policy; and
  - were not paid under the other benefit option; and
  - would have counted toward satisfaction of the Deductible and maximum payment limit under the other benefit option.



- Charges for Treatment or Service received by you or your Dependent while insured under one benefit option may be counted to determine the payment percentage under the other benefit option for the Calendar Year in which the transfer occurs, provided the charges are limited to those that:
  - would be Covered Charges under the Group Policy; and
  - were for Treatment or Service received during the Calendar Year in which the benefit option transfer occurred.
- Benefits will be payable under each benefit option only for Covered Charges incurred while insured under that particular benefit option.

If you are not Actively at Work on the effective date of the transfer, the benefit option in force for you before the transfer will continue to apply to you until the date of return to Active Work. When you return to Active Work, the new benefit option will then be in force for you. The benefit option elected by you will also apply to your Dependents.

## **HOW TO BE INSURED - MEMBERS**

### **DENTAL EXPENSE INSURANCE**

#### **Eligibility**

To be eligible for insurance you must be a Member.

**Member** means any PERSON ELECTING LOW DENTAL PLAN who is a Full-Time Employee of the Policyholder.

Member will also include any such person who is age 59.5 years of age with at least five years in an EPC Presbytery approved ministry who retires on or after January 1, 2017, provided he or she maintains continuous insurance with the Policyholder under the Group Policy.

If you are a Member on January 1, 2017, you will be eligible on that date.

If you are not a Member until later, you will be eligible on the first of the Insurance Month coinciding with or next following the date you begin Active Work.

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

#### **Effective Dates - Actively at Work**

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

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

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

#### **Individual Incontestability and Eligibility**

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

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

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

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

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

- in Writing and with 31-day notice, if the individual submits any claim that contains false or fraudulent elements under state or federal law; or
- in Writing and with 31-day notice, upon finding in a civil or criminal case that an individual has submitted claims that contain false or fraudulent elements under state or federal law; or
- in Writing and with 31-day notice, when an individual has submitted a claim which, in good faith judgment and investigation, an individual knew or should have known, contains false or fraudulent elements under state or federal law.

### **Effective Date for Noncontributory Insurance**

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

### **Effective Date for Contributory Insurance**

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

- the first of the Insurance Month coinciding with or next following the date you are eligible, if the request is made on or before that date; or
- the first of the Insurance Month coinciding with or next following the date you are eligible, if you make your request within 31 days after the date you are eligible; or
- the later of: (1) the date all other insurance under your plan is effective for you; or (2) the first of the Insurance Month coinciding with or next following the date of your request, if you make your request more than 31 days after the date you are eligible.

If request for insurance is made more than 31 days after the date an individual is eligible but during the Annual Enrollment Period or Special Enrollment Period described below, insurance for such individual will become effective as described below under "Annual Enrollment Period" or "Special Enrollment Period".

If request for insurance is made more than 31 days after the date an individual is eligible but as a result of a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN), insurance for such individual will become effective as described below.

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

In addition, your Dental Expense Insurance will be subject to the Benefit Waiting Period provisions described on GH 1107.

### **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.

For any Member or Dependent not previously insured under the Group Policy, the Benefit Waiting Period provisions described on GH 1107 do not apply during the Annual Enrollment Period.

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

- must meet the eligibility requirements described in the Group Policy, including satisfaction of any applicable waiting period; and
- may not be covered under an alternate dental expense coverage offered by the Policyholder, unless the Annual Enrollment Period happens to coincide with a separate open enrollment period established for coverage election.

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

The effective date for any qualified individual requesting insurance during the Annual Enrollment Period will be on January 1 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):** Benefit Waiting Period provisions as described on GH 1107 will not apply to you or your Dependent Child if:

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

The request for enrollment:

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

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

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

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

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

### **Special Enrollment Period**

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

The Special Enrollment Periods are:

- Loss of Other Coverage: A Special Enrollment Period will apply to you or your Dependent if all of the following conditions are met:
  - (i) the individual was covered under another group dental expense coverage at the time of his or her initial eligibility, and declined enrollment solely due to the other coverage; and
  - (ii) the other coverage terminated due to loss of eligibility (including loss due to divorce or legal separation, death, termination of employment or reduction in work hours, or if the other coverage was under a COBRA or state continuation provision, due to exhaustion of the continuation); and
  - (iii) request for enrollment is made within 31 days after the other coverage terminates.

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

NOTE: For the purpose of (ii) above:

"Loss of eligibility" does not include:

- (i) a loss due to failure of the individual to pay premiums on a timely basis or termination of insurance for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the dental expense 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, birth, adoption or Placement for Adoption; and
    - (iii) request for enrollment is made within 31 days after the date of the marriage, birth, adoption or Placement for Adoption, or the date Dependent Dental Expense Insurance is available to the Member under the Group Policy, if the request is made on or before the event or within 31 days after the event.

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

- (i) in the event of marriage, the date of such marriage; 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.

During a Special Enrollment Period, your Dental Expense Insurance will not be subject to the Benefit Waiting Period provisions described on GH 1107.

### **Effective Date for Benefit Changes**

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

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

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

### **Termination**

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

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

### **Continuation**

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

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

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

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

## HOW TO BE INSURED - DEPENDENTS

### DENTAL EXPENSE INSURANCE

#### Eligibility

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

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

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

You may elect to waive insurance for your Dependent Child until 31 days after the child's third birthday. If request for insurance is more than 31 days after your Dependent Child's third birthday, benefits will be subject to the Benefit Waiting Period provisions described on page GH 1107.

#### 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.

#### Individual Incontestability and Eligibility

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

#### Termination

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

- the end of the Insurance Month in which you cease to belong to a class for which Dependent Insurance is provided; or
- the date Dependent insurance is removed from the Group Policy; or
- the date your Member insurance ceases.

Insurance for any one Dependent will terminate on the 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, provided the spouse otherwise continues to be a Dependent.

However, Dental Expense Insurance will be continued beyond the maximum age for a Dependent Child who is incapable of self-support because of a Developmental Disability or Physical Handicap and is dependent on you for primary support. You must apply for this continuation within 31 days after the child reaches the maximum age.

**Continuation**

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



## **FEDERAL FAMILY AND MEDICAL LEAVE ACT (FMLA)**

### **Continuation**

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

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

### **FMLA and Other Continuation Provisions**

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

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

### **Eligible Employer**

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

### **Eligible Employee**

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

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

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

### **Mandated Unpaid Leave**

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

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

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

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

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

### **Reinstatement**

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

See your employer for details on this reinstatement provision.

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

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

### **Continuation**

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

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

The continuation provision will be in addition to any other continuation provisions described in the Group Policy for sickness, injury, layoff, or approved leave of absence, if any.

### **Reinstatement**

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

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

## **DESCRIPTION OF BENEFITS**

### **DENTAL EXPENSE INSURANCE (PAYMENT PROVISIONS)**

#### **Benefit Qualification**

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

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

#### **Benefits Payable**

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

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

## DENTAL EXPENSE INSURANCE

### BENEFIT PROVISIONS

#### Payment Conditions

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

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

as described in the SUMMARY OF BENEFITS Section.

#### Benefit Waiting Period (for when you request insurance more than 31 days after (1) the date eligible; or (2) the date you elect to terminate insurance)

Other than during an Annual Enrollment Period or Special Enrollment Period or coverage required under a QMCSO or NMSN as described on GH 1103, if you request insurance for you or your Dependent more than 31 days after the date the person is eligible, or you elect to terminate insurance and more than 31 days later request to be insured again, benefits will be limited as follows:

- During the first 12 months, benefits will be payable only for Dental Care Unit 1 (Preventive Procedures) Covered Charges.
- During the second 12 months, benefits will be payable only for Dental Care Unit 1 (Preventive Procedures) Covered Charges and Dental Care Unit 2 (Basic Procedures) Covered Charges.

After insurance has been in force for 24 consecutive months, benefits will be payable for charges incurred for Covered Charges under Dental Care Units 1 and 2.

These Benefit Waiting Period provisions will not apply to Covered Charges incurred for an Accidental Injury that results from an accident that occurred on or after your insurance or your Dependent's insurance became effective.

The premium rate charged for insurance under this Benefit Waiting Period provision will be the same as if benefits were not limited.

#### 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 begins (see below) while you and your Dependents are insured under the Group Policy; and
- Covered Charges will include only those charges for Treatment or Service that is completed while you and your Dependents are insured under the Group Policy (except when the Treatment or Service is covered under the Extended Benefits provision).

**Beginning Date for Treatment or Service**

Treatment or service will be considered to begin:

- for root canal therapy, on the date the pulp chamber is opened, and the pulp canal explored to the apex; and
- for all other, on the date the Treatment or Service is performed.

## DENTAL EXPENSE INSURANCE - LIMITATIONS

### Limitations

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

- Treatment or Service that is not a Covered Charge; or
- the services of any person who is not a Dentist or Dental Hygienist; or
- any part of a charge for Treatment or Service that exceeds Prevailing Charges; or
- the services of any person who is in an insured person's Immediate Family; or
- implants; or
- Treatment or Service that does not meet professionally recognized standards of quality; or
- veneers, anterior 3/4 cast crowns, personalization of dentures or crowns (or any other Treatment or Service that is primarily cosmetic); or
- drugs, medicines, or therapeutic drug injections; 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; 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 limitation will not apply to: partners, proprietors, or corporate officers of the employer who are not covered by a Workers' Compensation Act or other similar law; or

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



## SCHEDULE OF DENTAL PROCEDURES - UNIT 1

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

### **Dental Care Unit 1 - Preventive Procedures**

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

### **Dental Procedure**

#### **Examinations**

Only one of the below listed procedures will be covered in any six consecutive month period.

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.

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

#### **Radiographs**

##### **Full Mouth Survey**

Complete series (including bitewings)

Panoramic

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

##### **Bitewing**

Only one set will be covered in any Calendar Year.

##### **Occlusal**

Only two films will be covered in any Calendar Year.

##### **Periapical**

Only four films will be covered in any Calendar Year.

#### Extraoral X-Rays

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

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

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

#### **Preventive Services**

##### Prophylaxis (cleaning of teeth)

Limited to one dental prophylaxis in any six consecutive month period. Prophylaxis includes both routine cleaning and periodontal cleaning/maintenance procedures. The periodontal prophylaxis is paid under Unit 2. However, the service applies to the one prophylaxis limit.

##### Topical application of fluoride

Applicable only to Dependent Children under the age of 13. Only one application(s) will be covered in any Calendar Year.

## **SCHEDULE OF DENTAL PROCEDURES - UNIT 2**

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

### **Dental Care Unit 2 - Basic Procedures**

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

### **Dental Procedure**

#### **Restorations**

Fillings (amalgam or resin-based composite)

Anterior

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

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

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

Posterior

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

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

Replacement

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

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

Stainless Steel Crown

Prefabricated Resin Crown

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

## **Periodontic Services**

### 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 one dental prophylaxis (routine cleaning or periodontal cleaning/maintenance procedure) in any six consecutive month period.

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

## **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 Services**

### Emergency Examination (evaluation)

Coverage for Emergency Examination is limited to the frequency limitation described under examinations in Dental Care Unit 1.

### Consultation with specialist

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

### Antibiotic drug injection

### Office visit after regularly scheduled hours

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

### Palliative treatment

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

### Recementing

#### Inlay

#### Onlay

#### Crown

### Bridgework

Covered only if done more than 12 months after initial insertion of inlay, onlay, crown, or bridge, and than 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 13.

### Topical application of sealants

Applicable only to first and second permanent molars for Dependent Children under age 13. Covered once each tooth in any 36 consecutive month period.

### Space Maintainers

Applicable only to Dependent Children under age 13. Repairs to space maintainers are not covered. Limited to one bilateral space maintainer per arch or one unilateral space maintainer per quadrant.

## **DENTAL EXPENSE INSURANCE**

### **EXTENDED BENEFITS (after termination of insurance)**

If Dental Expense Insurance under the Group Policy ceases and if you or your Dependents qualify, We will pay for root canal therapy, but only if the pulp chamber was opened and the pulp canal explored to the apex while you or a Dependent were insured under the Group Policy.

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

You or a Dependent will qualify if:

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

However, no extended benefits will be paid for Treatment or Service received on or after the date you or your Dependents become eligible for other group dental expense coverage, unless Written documentation is provided that Treatment or Service began while you or your Dependent were insured under the Group Policy and the 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 provided under:

- any insured or noninsured group, service, prepayment, or other program arranged through an employer, trustee, union, or association; and
- any program required or established by state or Federal law (including Medicare Parts A and B); and
- any program sponsored by or arranged through a school or other educational agency; and
- the first-party medical expense provisions of any automobile policy issued under a no-fault insurance statute and traditional fault-type contracts.

The term Plan will not include benefits provided under a student accident policy, nor will the term Plan include benefits provided under a state medical assistance program where eligibility is based on financial need.

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

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

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

- If a person is covered by two or more Plans that compute their benefits payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.
- The amount a benefit is reduced by the Primary Plan because a covered person does not comply with the Plan provisions. Example of this provision is preferred provider arrangements.

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

### **Effect on Benefits**

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

- benefits are payable under any other Plan for the same Allowable Expenses; and
- the rules listed below provide that benefits payable under the other Plan are to be determined before the benefits payable under this Plan.

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

For this purpose:

- benefits payable under other Plans will include the benefits that would have been paid had claim been made for them;
- for any person covered by Medicare Part A, benefits payable will include benefits provided by Medicare Part B whether or not the person is covered under that Part B.

### **Order of Benefit Determination**

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

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

- Nondependent/Dependent. The Plan which covers the person as an employee, Member, or subscriber (that is, other than a Dependent) are determined before those of the Plan which covers the person as a Dependent. Exception: If the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
  - secondary to the Plan covering the person as a Dependent; and
  - primary to the Plan covering the person as other than a Dependent (e.g., a retired employee), then the benefits of the Plan covering the person as a Dependent are determined before those of the Plan covering that person as other than a Dependent.
- Dependent Child--Parents Not Separated or Divorced. If a Dependent Child is covered by both parents' Plans, the Plan of the parent whose birthday falls earlier in the Calendar Year will be determined before those of the Plan of the parent whose birthday falls later in that year. But, if both parents have the same birthday or if the



other Plan does not have a birthday rule, and as a result the Plans do not agree on the order of benefits, the benefits of the Plan which covered a parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

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

- Dependent Child--Separated or Divorced Parents. If a Dependent Child of legally separated or divorced parents is covered under two or more Plans, benefits for the Dependent Child are determined in this order:
  - first, the Plan of the parent with custody of the Dependent Child;
  - then, the Plan of the spouse of the parent with custody of the Dependent Child; and
  - finally, the Plan of the parent not having custody of the Dependent Child.

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

- Active/Inactive Employee. The benefits of a Plan which covers a person as an employee who is neither laid-off nor retired are determined before those of a Plan which covers that person as a laid-off or retired employee. The same would hold true if a person is a Dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.
- Continuation of Coverage. If a person for whom coverage is provided under a right of continuation according to Federal or state law is also covered under another Plan, the following will be the order of benefit determination:
  - first, the benefits of a Plan covering the person as an employee, Member, or subscriber (or as that person's Dependent);
  - second, the benefits under the continuation coverage.

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

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

### **Medicare Exception**

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

Federal law will usually apply in such instances if:

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

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

**How COB Works**

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

The following order of benefits would apply to the 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.

<u>Company A</u>		
Billed Charges	\$	600
Not Covered By Primary Carrier	\$	<u>- 20</u> (oral hygiene instructions)
Total Covered Charges	\$	580
Less Deductible	\$	<u>- 50</u>
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.

<u>Company B</u>		
Allowable Expenses	\$	580
Less Company A Benefits	\$	<u>-424</u>
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	\$	<u>- 20</u>	(oral hygiene instructions)
Total Covered Charges	\$	780	
Less Deductible	\$	<u>- 50</u>	
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	\$	<u>-584</u>	
Benefits Payable By Company B	\$	196	

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

**DENTAL EXPENSE INSURANCE**  
**COMPLAINT AND GRIEVANCE PROCEDURES**

**Applicability**

You or your Dependent or a designated representative or provider acting on behalf of you or your Dependent may file a Grievance if you are dissatisfied with any action We may have taken. A letter can be sent to the local service center (the address is shown on your ID card). The right to a Grievance does not apply to the providers' complaints concerning claim payment, handling, or reimbursement for dental care services.

As used in the Group Policy, "Grievance" means a complaint submitted by you or your Dependent or a designated representative or provider acting on behalf of you or your Dependent about any of the following:

- the availability, delivery, or quality of dental care services, including a complaint regarding an adverse determination as described on GH 1119 MI; or
- benefits or claim payment, handling, or reimbursement for dental care services; or
- matters pertaining to the contractual relationship between you or your Dependent and Us.

**Grievance Review**

Upon receipt of a Grievance, We will provide the claimant with the name, address, and telephone number of a person designated to coordinate the Grievance review. Written notification of the determination will be provided to you or your Dependent and the patient's Dentist, if applicable.

## **DENTAL EXPENSE INSURANCE**

### **EXTERNAL REVIEW**

#### **Right to Request an External Review of an Adverse Determination**

You or your Dependent or a designated representative or provider acting on behalf of you or your Dependent has the right to apply to the Insurance Director for an External Review of an Adverse Determination.

The external review request must be in Writing and be filed within 60 days of the receipt of the Adverse Determination.

The Insurance Director's address and telephone number is:

Consumer Services/Benefit Inquiry Section  
Department of Insurance and Financial Services  
P.O. Box 30220  
Lansing, MI 48909-7720  
1-877-999-6442

You or your Dependent must exhaust the complaint and grievance process as described on GH 1118 MI before requesting an external review.

When filing a request for an external review, you or your Dependent will be required to authorize the release of any dental records that may be required to be reviewed for the purpose of reaching a decision on the external review.

"Adverse Determination" means a determination by Us that, availability of care or other dental care service has been reviewed and based upon the information provided, does not meet the requirement for dental necessity, appropriateness, dental care setting, level of care and effectiveness, and the requested service is therefore denied, reduced, or terminated. Failure to respond in a timely manner to a request for a determination constitutes an Adverse Determination.

## **CLAIM PROCEDURES**

### **Notice of Claim**

Written notice of claim must be given to Us within 20 calendar days after the date of loss. Failure to give notice within the time specified will not invalidate or reduce any claim if notice is given as soon as reasonably possible.

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

### **Payment, Denial, and Review**

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

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

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

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

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

### **Recoding of Procedures**

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

If We determine, 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 60 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.



## 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.

**Benefit Waiting Period** means the period of time that must pass before an individual or a group is covered for specified benefits under the Group Policy. This benefit waiting period is further described on GH 1107.

**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.

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

**Dental Charges Database (DCD)** means a 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.

**Dependent** means:

- your spouse, if your spouse:
  - is not in the Armed Forces of any country; and
  - is not insured under the Group Policy as a Member.
- your Dependent Child (or Children) as defined below.

**Dependent Child; Dependent Children** means:

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

An adopted child will be considered a Dependent Child on the earlier of: the date the petition for adoption is filed; or the date of entry of an order granting the adoptive parent custody of the child for the purpose of adoption.

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

**Developmental Disability** means a Dependent Child's substantial handicap, 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, as determined by Us, which is rendered as the direct result of an unforeseen occurrence or combination of circumstances which requires immediate, urgent action or remedy.

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

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

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

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

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

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

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

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

**Insurance Month** means calendar month.

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

**Member** means any PERSON ELECTING LOW DENTAL PLAN who is a Full-Time Employee of the Policyholder.

Member will also include any such person who is age 59.5 years of age with at least five years in an EPC Presbytery approved ministry who retires on or after January 1, 2017, and who maintains continuous coverage with the Policyholder under the Group Policy.

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

**Orthodontic Treatment or Service** means any Treatment or Service for:

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

**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.

**Policyholder** means EVANGELICAL PRESBYTERIAN CHURCH and shall include any affiliate or subsidiary of the Policyholder participating under the Group Policy.

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

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

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

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

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

**Prevailing Charges** means:

- For dental care received from 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 an amount that is equal to the negotiated fee amount described above. Non-Preferred Providers may charge you or your Dependent the difference between the actual cost charged and the Prevailing Charge.

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

**Second Opinion Consultation Charges** means Covered Charges for:

- consultation with a Second Opinion Physician to obtain a Second Opinion prior to a Treatment or Service for which a Second Opinion is recommended; and
- necessary diagnostic, x-ray or laboratory examinations performed in connection with such consultation.

**Second Opinion Physician** means a Physician or Dentist who is:

- an appropriate specialist for the particular Treatment or Service recommended; and
- not a partner or associate of the Physician or Dentist who recommended or will perform the Treatment or Service.

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

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

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

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

## 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 medical expense, group dental expense and/or group vision care expense insurance with us ("insurance"). This Notice was effective April 14, 2003 and revisions to this Notice are effective February 2, 2012.

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: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, Des Moines, IA 50392-0002. A form to revoke an authorization can be obtained from the Health Information Protection Analyst.

**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 perform a hospital admission review to determine whether services are for medically necessary care 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, 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 will only use or disclose AIDS/HIV-related information, genetic testing information and information pertaining to your mental condition or any substance abuse problems as permitted by state and federal law or regulation.

### **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. To request a restriction, you must send a written request to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0002. A form to request a restriction can be obtained from the Health Information Protection Analyst. 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. To request a confidential communication, you must send a written request to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0002. A form to request a confidential communication can be obtained from the Health Information Protection Analyst.

**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. To request access to your information, you must send a written request to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0002. A form to request access to your health information can be obtained from the Health Information Protection Analyst. 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. To request an amendment, you must send a written request to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0002. A form to request an amendment to your health information can be obtained from the Health Information Protection Analyst. 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 made by us after April 14, 2003, of your health information. To request an accounting, you must send a written request to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0002. A form to request an accounting of your health information can be obtained from the Health Information Protection Analyst. 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.

**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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**Plan Arranged By**

**MESIROW INSURANCE SERVICES INC**  
353 NORTH CLARK ST  
CHICAGO IL  
60654



**Principal Life Insurance Company**  
Des Moines, Iowa 50392-0002