PLAN SPONSOR ACCEPTANCE OF RESPONSIBILITY

PLEASE SIGN BELOW TO ACKNOWLEDGE YOUR ACCEPTANCE OF RESPONSIBILITY FOR THE CONTENTS OF THIS DOCUMENT AND RETURN THIS SIGNED FORM TO:

EBA&M
P.O. Box 5079
Westlake Village, CA 91359

We, the Plan Sponsor, recognize that we have full responsibility for the contents of the Benefit Document and that, while the Contract Administrator, its employees and/or subcontractors, may have assisted in the preparation of the document, we are responsible for the final text and meaning. We further certify that the document has been fully read, understood, and describes our intent with regard to our employee welfare plan.

Benefit Document of the Dental Benefits

Plan Sponsor/Plan Administrator: Garden Grove Unified School District

Signed (authorized representative of Plan Sponsor) Date

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GARDEN GROVE UNIFIED SCHOOL DISTRICT

BENEFIT DOCUMENT

OF THE

DENTAL BENEFITS

NOTE: THESE BENEFITS ARE PART OF THE
"GARDEN GROVE UNIFIED SCHOOL DISTRICT SELF-INSURED HEALTH PLAN"

RESTATED EFFECTIVE: JANUARY 1, 2017

Contract Administrator:

EBA&M Corporation
P.O. Box 5079
Westlake Village, CA 91359

Phone: (800) 249-8440 / Fax: (714) 546-0141

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WHO TO CONTACT FOR ADDITIONAL INFORMATION

A Plan participant can obtain additional information about Plan coverage of a specific drug, treatment, procedure, preventive service, etc. from the office who handles claims on behalf of the Plan (the "Contract Administrator"). See the first page of the **General Plan Information** section for the name, address and phone number of the Contract Administrator.

DENTAL BENEFIT SUMMARY

CHOICE OF PROVIDERS

The Plan Sponsor has contracted with an organization or "Network" of dental providers. Network providers have agreed to provide dental services at negotiated rates. When obtaining dental care services, a Covered Person has a choice of using a provider who is participating in the Network or any other Covered Provider of his choice (a Non-Network provider).

Since Network providers have agreed to provide services to Covered Persons at negotiated rates, when a Covered Person uses a Network provider his out-of-pocket costs may be reduced because he will not be billed for expenses in excess of "Usual, Customary and Reasonable."

PLAN MAXIMUMS	
Calendar Year Maximum Benefit for Regular Dental Services	$2,000
Orthodontia Lifetime Maximum Benefit	$2,800
Plan benefits for each Covered Person will not exceed the maximums shown above. Orthodontia benefits do not apply to the Calendar Year Maximum Benefit. The Orthodontia Lifetime Maximum Benefit applies to all periods a person is covered under the Plan.	
CALENDAR YEAR DEDUCTIBLES	
Individual Deductible	$25
Family Maximum Deductible	$75
Individual Deductible - The Individual Deductible is an amount that a Covered Person must contribute toward payment of eligible dental expenses. Usually, the deductible applies before the Plan begins to provide benefits. Family Maximum Deductible - If $75 in eligible dental expenses is incurred cumulatively by family members during a Calendar Year and is applied toward Individual Deductibles, the Family Maximum Deductible is satisfied. A "family" includes a covered Employee and his covered Dependents.	

ELIGIBLE DENTAL EXPENSES	**Covered Person Pays**	**Plan Pays**
Regular Dental Services	10%	90%
Limits applicable to certain Regular Dental Services: - routine oral examinations and cleanings are limited to 4 exams/cleanings per year (1 per quarter); - fluoride treatment is limited to children through age 15.		
Orthodontia	50%†	50%†

† Calendar Year Deductible does not apply.

THIS IS A SUMMARY ONLY. PLEASE REFER TO THE **ELIGIBLE DENTAL EXPENSES** AND **DENTAL LIMITATIONS AND EXCLUSIONS** SECTIONS FOR MORE INFORMATION.

DENTAL PRE-TREATMENT ESTIMATE

A treatment plan describing orthodontic or periodontic treatment or any other course of treatment for which Eligible Expenses are expected to total at least $250, must be submitted to the Contract Administrator within twenty (20) days following the examination which reveals the need for such treatment. **All crowns must be pre-authorized.**

The attending Dentist must submit a completed claim form, including an itemization of his fees and copies of pertinent X-rays. The Contract Administrator may require additional information in order to complete the pre-authorization, including, but not limited to, a complete dental chart showing any prior extractions, fillings or other work performed previously, itemized laboratory or hospital reports, cast molds, study models or other similar evidence of the condition or treatment of the teeth or mouth.

While failure to obtain a pre-authorization probably won't reduce Plan benefits, it does serve two (2) useful purposes. First, it gives the Covered Person and his dentist a good idea of benefit levels, maximums, limitations, etc., that might apply to the treatment program so that the Covered Person can anticipate what portion of the cost will be his responsibility and, secondly, it offers the Covered Person and his dentist an opportunity to consider other avenues of restorative care that might be equally satisfactory and less costly to the Plan and to himself.

NOTE: A PRE-TREATMENT ESTIMATE IS NOT A GUARANTEE OF PAYMENT. PAYMENT OF PLAN BENEFITS IS SUBJECT TO PLAN PROVISIONS AND ELIGIBILITY AT THE TIME THE SERVICES ARE ACTUALLY INCURRED.

ELIGIBLE DENTAL EXPENSES

Eligible dental expenses are the Allowable Amounts for the dental services and supplies that are listed below and: (1) incurred while a person is covered under the Plan, and (2) received from a licensed dentist, a qualified technician working under a dentist's supervision or any Physician furnishing dental services for which he is licensed.

For benefit purposes, dental expenses will be deemed incurred as follows:

for an appliance or modification of an appliance, on the date the final impression is taken;

for a crown, bridge or gold restoration, on the date the tooth is prepared;

for root canal therapy, on the date the pulp chamber is opened; or

for all other services, on the date the service is rendered.

NOTE: Many dental conditions can be properly treated in more than one (1) way. The Plan is designed to help pay for dental expenses, but not for treatment which is more expensive than necessary for good dental care. If a Covered Person chooses a more expensive course of treatment, the Plan will pay benefits equivalent to the least expensive treatment that would adequately restore the dental condition.

REGULAR DENTAL SERVICES

Anesthesia - General anesthesia when administered in connection with oral surgery.

NOTE: Separate charges for pre-medication, local anesthesia, analgesia or conscious sedation are not covered. Such services should be included in the cost of the procedure itself.

Consultation - Consultation by a dental specialist upon referral by the patient's attending dentist.

Crowns - A stainless steel, gold, porcelain or composite crown restoration when a tooth cannot be satisfactorily restored with a filling restoration. Coverage for a crown includes a post and core when necessary.

See "Cosmetic Dentistry" in the list of **Dental Limitations and Exclusions** for restrictions on veneer or facing (i.e., "tooth-colored") restorations. Crowns placed for the purpose of periodontal splinting are not covered.

Endodontia - Endodontic services, including root canal therapy (except for final restoration), pulpotomy, apicoectomy and retrograde filling.

Exams - Diagnostic oral examinations.

Extractions - Dental extractions, including those for orthodontic purposes.

Fillings - Amalgam, silicate, composite, plastic and gold restorations.

Fluoride Applications - Fluoride treatment for children under age 15.

Implants - Implants (materials implanted into or on bone or soft tissue) and all related services or supplies, or the removal of implants.

Note: Implants to replace an existing bridge will be allowed only if existing bridge is more than five (5) years old.

Injections - Injection of antibiotic drugs.

Inlays

Onlays

Oral Surgery - Surgical and adjunctive treatment of disease, injury and defects of the oral cavity and associated structures.

Pathology - Diagnostic laboratory services performed to assist in the diagnosis of oral disease.

Periodontia - Treatment of the gums and tissues of the mouth, including periodontal scaling and root planing.

Prescription Drugs

Prophylaxis - Cleaning and polishing of the teeth.

Prosthetics - Initial, Additions & Replacement - Full and partial dentures, fixed and removable bridgework and the addition of teeth to partial dentures or fixed bridgework - but only for the replacement of natural teeth which have been lost or extracted.

Replacements of prosthetics which are more than five (5) years old and then only if the existing prosthetic cannot be made satisfactory.

Prosthetic Repairs - Repairs or recementing of crowns, inlays, bridgework or dentures or the relining of dentures.

Sealants - Materials applied to the pits and fissures of the teeth, with the intent to seal the tooth and reduce the incidence of decay.

Space Maintainers - Fixed or removable space maintainers for missing primary teeth.

X-rays

ORTHODONTIA

Services or supplies for the correction of bite or malocclusion or for the alignment or repositioning of teeth, including:

initial consultation, models, X-rays and other diagnostic services;

initial banding or placement of orthodontic appliance(s);

periodic adjustments; and

retainers.

Orthodontia services must be in accordance with a treatment plan that has been reviewed and approved by the Contract Administrator prior to the commencement of services (see Dental Pre-treatment Estimate section).

Orthodontia benefits will begin upon submission of proof that the orthodontia appliances have been installed. Payments will be divided into equal installments, based upon the estimated number of months of treatment, and will be paid over the remaining treatment period as proof of continuing treatment is submitted. The benefit maximums for orthodontia services are shown in the “Plan Maximums” in the Dental Benefit Summary.

DENTAL LIMITATIONS AND EXCLUSIONS

Except as specifically stated, no benefits will be payable hereunder for:

Appliances - Items intended for sport or home use, such as athletic mouthguards or habit-breaking appliances.

Congenital or Developmental Conditions - Treatment of congenital (hereditary) or developmental (following birth) malformations.

Cosmetic Dentistry - Treatment rendered for cosmetic purposes.

Excess charges for a veneer or facing (i.e., a "tooth-colored" exterior) on a crown or pontic or excess charges for a tooth-colored restoration. The maximum allowance will be the allowance for the least costly restoration that will provide a functional result.

Customized Prosthetics - Excess charges for precision or semi-precision attachments, overdentures, or customized prosthetics.

Discoloration Treatment - Teeth whitening or any other treatment to remove or lessen discoloration, except in connection with endodontia.

Excess Care - Services that exceed those necessary to achieve an acceptable level of dental care. If it is determined that alternative procedures, services, or courses of treatment could be (could have been) performed to correct a dental condition, Plan benefits will be limited to the least costly procedure(s) that would produce a professionally satisfactory result.

Duplicate prosthetic devices or appliances.

Excess Charges - Charges in excess of the Allowable Amount for dental services or supplies.

Experimental Procedures - Services that are considered experimental or that are not approved by the American Dental Association.

Hospital Expenses

Lost or Stolen Prosthetics or Appliances - Replacement of a prosthetic or any other type of appliance that has been lost, misplaced, or stolen.

Medical Expenses - Any dental-related services to the extent to which coverage is provided under the terms of the medical benefits of this Plan.

Myofunctional Therapy - Muscle training therapy or training to correct or control harmful habits.

Non-Professional Care - Services rendered by someone other than:

a dentist (DDS or DMD);

a dental hygienist, X-ray technician or other qualified technician who is under the supervision of a dentist; or

a Physician furnishing dental services for which he is licensed.

Occlusal Restoration - Procedures, appliances or restorations that are performed to alter, restore or maintain occlusion (i.e., the way the teeth mesh), including:

increasing the vertical dimension;

replacing or stabilizing tooth structure lost by attrition;

realignment of teeth;

gnathological recording or bite registration or bite analysis;

occlusal equilibration.

Oral Hygiene Instruction & Supplies, Etc. - Dietary or nutritional counseling or related supplies, personal oral hygiene instruction or plaque control. Oral hygiene supplies including but not limited to: toothpaste, toothbrushes, waterpiks, and mouthwashes.

Personalization or Characterization of Dentures

Prior to Effective Date / After Termination Date - Courses of treatment that began prior to the Covered Person's effective date, including crowns, bridges or dentures that were ordered prior to the effective date.

Expenses incurred after termination of coverage.

Splinting - Appliances or restorations for splinting teeth.

TMJ Treatment / Jaw Surgery - Procedures, restorations or appliances for the treatment or for the prevention of temporomandibular joint dysfunction syndrome.

NOTE: This exclusion will not apply to diagnostic studies.

*- (See also **General Exclusions** section) -*

GENERAL EXCLUSIONS

The following exclusions apply to all dental benefits and no benefits will be payable for:

Criminal Activities - Any injury resulting from or occurring during the Covered Person's commission or attempt to commit an aggravated assault or felony, taking part in a riot or civil disturbance, or taking part as a principal or as an accessory in illegal activities or an illegal occupation.

Excess Charges - Charges that are not payable under the Plan due to application of any Plan maximum or limit or because the charges are in excess of the Usual and Customary amount, or are for services not deemed to be Reasonable or Medically Necessary, based upon the Plan Administrator's determination as set forth by and within the terms of this document.

Forms Completion - Charges made for the completion of claim forms or for providing supplemental information.

Late-Filed Claims - Claims which are not filed with the Contract Administrator for handling within the required time periods as included in the **Claims Procedures** section.

Missed Appointments - Expenses incurred for failure to keep a scheduled appointment.

No Charge / No Legal Requirement to Pay - Services for which no charge is made or for which a Covered Person is not required to pay, or is not billed or would not have been billed in the absence of coverage under this Plan. However, this exclusion does not apply to any benefit or coverage which is available through the Medical Assistance Act (Medicaid).

Not Listed Services or Supplies - Any services, care or supplies not specifically listed as Eligible Expenses.

Other Coverage - Services or supplies for which a Covered Person is entitled (or could have been entitled if proper application had been made) to have reimbursed by or furnished by any plan, authority or law of any government, governmental agency (Federal or State, Dominion or Province or any political subdivision thereof).

Outside United States - Charges incurred outside of the United States if the Covered Person traveled to such a location for the sole purpose of obtaining such services, drugs or supplies.

Postage, Shipping, Handling Charges, Etc. - Any postage, shipping or handling charges which may occur in the transmittal of information to the Contract Administrator. Interest or financing charges.

Prior Coverages - Services or supplies for which the Covered Person is eligible for benefits under the terms of the document that this Benefit Document replaces.

Relative or Resident Care - Any service rendered to a Covered Person by a relative (i.e., a spouse, or a parent, brother, sister, or child of the Employee or of the Employee's spouse) or anyone who customarily lives in the Covered Person's household.

Telecommunications - Advice or consultation given by or through any form of telecommunication.

War or Active Duty - Health conditions resulting from insurrection, war (declared or undeclared) or any act of war and any complications therefrom, or service (past or present) in the armed forces of any country, to the extent not prohibited by law.

Work-Related Conditions - Any condition for which the Covered Person has or had a right to compensation under any Workers' Compensation or occupational disease law or any other legislation of similar purpose, whether or not a claim is made for such benefits. If the Plan provides benefits for any such condition, the Plan Sponsor will be entitled to establish a lien upon such other benefits up to the amount paid.

Any condition which arises from or is sustained in the course of any occupation or employment for compensation, profit or gain.

COORDINATION OF BENEFITS (COB)

All dental care benefits provided under the Plan are subject to Coordination of Benefits as described below, unless specifically stated otherwise.

DEFINITIONS

As used in this COB section, the following terms will be capitalized and will have the meanings indicated:

Other Plan - Any of the following that provides dental care benefits or services:

group, blanket or franchise insurance coverage;

group hospital or medical service prepayment plans (HMOs, PPOs, EPOs);

group automobile insurance;

individual auto insurance based upon the principles of "No Fault" coverage;

any coverage under labor-management trusteed plans, union welfare plans, employer or professional organization plans, or employee benefit organization plans;

any coverage under government programs including Medicare, TRICARE, and any coverage required or provided by a statute. For purposes of implementing this provision, eligibility alone will constitute coverage;

any group coverage sponsored by or provided through a school or other educational institution.

NOTES: An "Other Plan" includes benefits that are actually paid or payable or benefits that would have been paid or payable if a claim had been properly made for them.

If an Other Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

The Contract Administrator shall not be required to determine the existence of any Other Plan, or the amount of benefits payable under any Other Plan. The payment of benefits under This Plan shall be affected by the benefits payable under Other Plans only if the Contract Administrator is furnished with information concerning the existence of such Other Plans by the Employer, covered Employee/Retiree, or any other insurance company, organization or person.

This Plan - The coverages of this Plan.

Allowable Expense - A dental care service or expense, including deductibles and copayments, that is covered at least in part by any of the plans (i.e., This Plan or Other Plan(s)) covering the Claimant. When a plan provides benefits in the form of services (an HMO, for example), the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid.

Any 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 (2) or more plans that compute benefits on the basis of usual and customary allowances, any amount in excess of the highest usual and customary allowance is not an Allowable Expense.

If a person is covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the lowest of the negotiated fee is not an Allowable Expense.

If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary and another plan that provides its benefits or services on the basis of negotiated fees, the lesser of those amounts shall be the Allowable Expense for This Plan.

Claim Determination Period - A period that commences each January 1 and ends at 12 o'clock midnight on the next succeeding December 31, or that portion of such period during which the Claimant is covered under This Plan. The Claim Determination Period is the period during which This Plan's normal liability is determined (see "Effect on Benefits Under This Plan").

Custodial Parent - A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation.

EFFECT ON BENEFITS UNDER THIS PLAN

When Other Plan Does Not Contain a COB Provision - If an Other Plan does not contain a coordination of benefits provision that is consistent with the NAIC Model COB Contract Provisions, then such Other Plan will be "primary" and This Plan will pay its benefits AFTER such Other Plan(s). This Plan's liability will be its normal liability minus benefits paid or payable by the Other Plan(s).

When Other Plan Contains a COB Provision - When an Other Plan also contains a coordination of benefits provision similar to this one, This Plan will determine its benefits using the "Order of Benefit Determination Rules" below. If, in accordance with those rules, This Plan is to pay benefits BEFORE an Other Plan, This Plan will pay its normal liability without regard to the benefits of the Other Plan. If This Plan, however, is to pay its benefits AFTER an Other Plan(s), it will pay its normal liability minus benefits paid or payable by the Other Plan(s).

NOTE: The determination of This Plan's "normal liability" will be made on a claim-by-claim basis. No savings or credit reserves will be recognized.

ORDER OF BENEFIT DETERMINATION RULES

If an “Other Plan” has a COB provision, whether This Plan is the "primary" plan or a "secondary" plan is determined in accordance with the following rules.

Non-Dependent vs. Dependent - The benefits of a plan that covers the Claimant other than as a dependent will be determined before the benefits of a plan that covers such Claimant as a dependent.

Child Covered Under More Than One Plan - When the Claimant is a dependent child, the primary plan is the plan of the parent whose birthday is earlier in the year if: (1) the child's parents are married, (2) the parents are not separated (whether or not they have ever been married), or (3) a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

When the Claimant is a dependent child and the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.

When the Claimant is a dependent child whose father and mother are not married, are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

the plan of the Custodial Parent;

the plan of the spouse of the Custodial Parent;

the plan of the noncustodial parent; and then

the plan of the spouse of the noncustodial parent.

“Custodial Parent” means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides for more than half the Calendar Year without regard to any temporary visitation.

Active vs. Inactive Employee - The plan that covers the Claimant as an employee who is neither laid off nor retired, is primary. The plan that covers a person as a dependent of an employee who is neither laid off nor retired, is primary. 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 is ignored.

The plan that covers the Claimant as an active employee or a dependent of an active employee is primary over a plan providing coverage under a right of continuation pursuant to federal or state law (e.g. COBRA). 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 is ignored.

Longer vs. Shorter Length of Coverage - If none of the above rules establish which plan is primary, the benefits of the plan that has covered the Claimant for the longer period of time will be determined before those of the plan that has covered that person for the shorter period of time.

NOTE: If the preceding rules do not determine the primary plan, the Allowable Expenses shall be shared equally between This Plan and the Other Plan(s). However, This Plan will not pay more than it would have paid had it been primary.

OTHER INFORMATION ABOUT COORDINATION OF BENEFITS

Right to Receive and Release Necessary Information - For the purpose of enforcing or determining the applicability of the terms of this COB section or any similar provision of any Other Plan, the Contract Administrator may, without the consent of any person, release to or obtain from any insurance company, organization or person any information with respect to any person it deems to be necessary for such purposes. Any person claiming benefits under This Plan will furnish to the Contract Administrator such information as may be necessary to enforce this provision.

Facility of Payment - A payment made under an Other Plan may include an amount that should have been paid under This Plan. If it does, the Contract Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Plan will not have to pay that amount again.

Right of Recovery - If the amount of the payments made by the Plan is more than it should have paid under this COB section, the Plan may recover the excess from one or more of the persons it has paid or for whom it has paid - or any other person or organization that may be responsible for the benefits or services provided for the Claimant. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

ELIGIBILITY AND EFFECTIVE DATES

Eligibility & Effective Dates - Employees

Eligibility Requirements - In order to be eligible to participate in the dental coverages of the Plan, an Employee must be in active full-time (non-temporary) employment for the Employer, performing all customary duties of his occupation at his usual place of employment (or at a location to which the business of the Employer requires him to travel) and regularly scheduled to work based on the bargaining contract.

An Employee will be deemed in "active employment" on each day he is actually performing services for the Employer and on each day of a regular paid vacation or on a regular non-working day, provided he was actively at work on the last preceding regular working day. An Employee will also be deemed in "active employment" on any day he is absent from work during an approved FMLA leave or other paid leave, or solely due to his own ill health.

Coverage Effective Date - An Employee's coverage is effective on the first of the month following his first day of "active employment" in an eligible status.

When "active employment" begins on the first day of a calendar month, coverage is effective immediately.

NOTE: Coverage is never automatic. Enrollment forms for all persons MUST be completed at the District Insurance Office within 31 days of eligibility date.

See **Extension of Coverage** section(s) for instances when these eligibility requirements may be waived or modified.

Eligibility & Effective Date - Dependents

Eligibility Requirements - An eligible Dependent of an Employee is:

a legally married spouse. "Legally married" means a legal union (as defined by the Employee's state of residence) between two individuals. An eligible spouse will not include a common law spouse;

a registered domestic partner when the partner and Employee have registered their domestic partnership with the Secretary of State of the State of California. The State of California permits state registration of: (1) same-sex domestic partnerships, and (2) opposite-sex partnerships after one partner attains age 62. A domestic partnership registration from outside of California will be recognized on the same basis as a California state-registered domestic partnership only if the out-of-California partnership is a legal union of two persons of the same sex, other than a marriage, and is substantially equivalent to a registered California domestic partnership. This applies regardless of whether it bears the name "domestic partnership," Domestic partners who register only with their cities, counties or employers are not eligible;

a child who is under age 26 (i.e., up to but not including the child's 26th birthday). The child need not: (1) reside with the Employee or any other person, (2) be a student, (3) be a tax-code dependent of the Employee, (4) be unmarried, or (5) be unemployed. An eligible Dependent child will include:

- a natural child;
- a stepchild;
- a child placed under the legal guardianship of the Employee;
- a child who is adopted by the Employee or placed with him for adoption;
- a child for whom Plan coverage is required due to a Medical Child Support Order (MCSO) that the Plan Sponsor determines to be a Qualified Medical Child Support Order in accordance with its written procedures (that are incorporated herein by reference and that can be obtained without charge). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under state law and that satisfies the QMCSO requirements of ERISA (section 609(a)).

NOTES: An eligible Dependent does not include:

a spouse following legal separation or a final decree of dissolution or divorce;

a domestic partner following the automatic termination of the Domestic Partnership 6 months after the filing of a Notice of Termination of Domestic Partnership with the Secretary of State of the State of California. The termination of a domestic partnership will be treated as equivalent to a divorce between a husband and wife;

any spouse or domestic partner who is on active duty in a military service, to the extent permitted by law.

See the **Extensions of Coverage** section for instances when these eligibility requirements may be waived or modified.

Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining a Dependent's eligibility.

Effective Date - All Dependents, except adoptive children, shall have coverage effective on the first of the month following the date they become eligible. A Dependent's coverage will not become effective prior to the Employee's/Retiree's coverage effective date.

NOTE: Coverage is never automatic. Enrollment forms for all persons MUST be completed at the District Insurance Office within thirty-one (31) days of the Dependent's eligibility date.

Newborn and Adoptive Children - A Dependent child born after the effective date of Employee's coverage is eligible and covered from birth. However, the Plan Sponsor and Contract Administrator must be notified of the birth and the child must be properly enrolled within thirty-one (31) days of birth.

An adoptive child who is placed with the Employee within thirty-one (31) days of birth will be covered from birth. Any other adoptive child will be covered from the date the child is adopted by the Employee or the date he is placed with the Employee for adoption. "Placement for adoption" means the assumption and retention by the Employee of the legal obligation for the total or partial support of a child to be adopted. Placement ends whenever the legal support obligation ends.

Reinstatement / Rehire

If an Employee returns to active employment and eligible status following an approved leave of absence in accordance with the Employer's guidelines and the Family and Medical Leave Act (FMLA), and during the leave Employee discontinued paying his share of the cost of coverage causing coverage to terminate, such Employee may have coverage reinstated (for himself and any Dependents who were covered at the point contributions ceased). However, Employee must request that coverage be restored before his family or medical leave expires. No waiting period requirement will be applied.

In accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), certain Employees who return to active employment following active duty service as a member of the United States armed forces will be reinstated to coverage under the Plan immediately upon returning from military service. Additional information concerning the USERRA can be obtained from the Plan Sponsor.

NOTES: Except in the above instances, any terminated Employee who is rehired will be treated as a new hire and will be required to satisfy all eligibility and enrollment requirements.

Benefits for any Employee or Dependent who is covered under the Plan, whose employment or coverage is terminated, and who is subsequently rehired or reinstated at any time, shall be limited to the maximum benefits that would have been payable had there been no interruption of employment or coverage.

Dual Coverage

When a husband and wife are both enrolled as Employees, each has the option to enroll eligible Dependents for coverage hereunder. The combined maximum Plan benefits shall not exceed the aggregate of 100 percent of the Allowable Amount(s) for the Eligible Expense(s).

Transfer of Coverage

If a husband and wife are both Employees and are covered as Employees under this Plan and one of them terminates, the terminating spouse and any of his eligible and enrolled Dependents will be permitted to immediately enroll under the remaining Employee's coverage. Such new coverage will be deemed a continuation of prior coverage and will not operate to reduce or increase any coverage to which the person was entitled while enrolled as the Employee or the Dependent of the terminated Employee.

If a Covered Person changes status from Employee to Dependent or vice versa, and the person remains eligible and covered without interruption, then Plan benefits will not be affected by the person's change in status.

TERMINATION OF COVERAGE

Employee Coverage Termination

Except as noted, an Employee's coverage under the Plan will terminate upon the earliest of the following:

termination of the Plan benefits as described herein;

termination of participation in the Plan by the Employee;

the end of the period for which Employee last made the required contribution, if the coverage is provided on a contributory basis (i.e. Employee shares in the cost);

at midnight on the last day of the month in which the covered Employee leaves or is dismissed from the employment of the Employer, ceases to be eligible, or ceases to be engaged in active employment for the required number of hours as specified in **Eligibility and Effective Dates** section - except when coverage is extended under the **Extensions of Coverage** section;

the date the Employee dies (see note below regarding dependent termination date).

NOTE: An Employee otherwise eligible and validly enrolled under the Plan shall not be terminated from the Plan solely due to his need for dental services.

Dependent Coverage Termination

Except as noted, a Dependent's coverage under the Plan will terminate upon the earliest of the following:

termination of the Plan or discontinuance of Dependent coverage under the Plan;

termination of the coverage of the Employee;

at midnight of the last day the Dependent meets the eligibility requirements of the Plan, except when coverage is extended under the **Extensions of Coverage** section. An Employee's adoptive child ceases to be eligible on the date on which the petition for adoption is dismissed or denied or the date on which the placement is disrupted prior to legal adoption and the child is removed from placement with the Employee;

the end of the period for which the Employee last made the required contribution for such coverage, if Dependent's coverage is provided on a contributory basis (i.e., Employee shares in the cost). However, in the case of a child covered due to a Qualified Medical Child Support Order (QMCSO), the Employee must provide proof that the child support order is no longer in effect or that the Dependent has replacement coverage that will take effect immediately upon termination.

NOTES: A Dependent otherwise eligible and validly enrolled under the Plan shall not be terminated from the Plan solely due to his need for dental services.

Dependent termination due to Employee death will be at midnight of the last day of the month in which the Employee dies.

EXTENSIONS OF COVERAGE

Coverage may be continued beyond the **Termination of Coverage** date in the circumstances identified below. Unless expressly stated otherwise, however, coverage will not extend: (1) beyond the date the Plan is terminated, and (2) for a Dependent, beyond the date the Employee's coverage ceases.

Extension of Coverage for Developmentally Disabled or Handicapped Dependent Children

If a covered Dependent child attains the age that would otherwise terminate his status as a "Dependent," and:

if on the day immediately prior to the attainment of such age the child was a covered Dependent under the Plan;

at the time of attainment of such age the child is incapable of self-sustaining employment by reason of mental retardation, cerebral palsy, epilepsy, other neurological disorder, physical handicap, or disability due to injury, accident, congenital defect or sickness;

the child's condition has been diagnosed by a Physician as a permanent or long-term dysfunction or condition; and

such child is primarily dependent upon the Employee for support and maintenance;

then such child's status as a "Dependent" will not terminate solely by reason of his having attained the limiting age and he will continue to be considered a covered Dependent under the Plan so long as he remains in such condition, and otherwise conforms to the definition of "Dependent."

The Employee must submit proof of the child's incapacity to the Plan Administrator within thirty-one (31) days of the child's attainment of the limiting age, and thereafter as may be required, but not more frequently than once a year after the two-year period following the child's attainment of such age.

Extension of Coverage During U.S. Military Service

Regardless of an Employer's established termination or leave of absence policies, the Plan will at all times comply with the regulations of the Uniformed Services Employment and Reemployment Rights Act (USERRA) for an Employee entering military service.

An Employee who is ordered to active military service is (and the Employee's eligible Dependent(s) are) considered to have experienced a COBRA qualifying event. The affected persons have the right to elect continuation of coverage under either USERRA or COBRA. Under either option, the Employee retains the right to re-enroll in the Plan in accordance with the stipulations set forth herein.

Notice Requirements - To be protected by USERRA and to continue dental coverage, an Employee must generally provide the Employer with advance notice of his military service. Notice may be written or oral, or may be given by an appropriate officer of the military branch in which the Employee will be serving. Notice will not be required to the extent that military necessity prevents the giving of notice or if the giving of notice is otherwise impossible or unreasonable under the relevant circumstances. If the Employee's ability to give advance notice was impossible, unreasonable or precluded by military necessity, then the Employee may elect to continue coverage at the first available moment and the Employee will be retroactively reinstated in the Plan to the last day of active employment before leaving for active military service. The Employee will be responsible for payment of all back premiums from date of termination of Plan coverage. No administrative or reinstatement charges will be imposed.

If the Employee provides the Employer with advance notice of his military service but fails to elect continuation of coverage under USERRA, the Plan Administrator will continue coverage for the first thirty-one (31) days after Employee's departure from employment due to active military service. The Plan Administrator will terminate coverage if Employee's notice to elect coverage is not received by the end of the 31-day period. If the Employee subsequently elects to continue coverage while on active military service and within the time set forth in the subsection entitled "Maximum Period of Coverage" below, then the Employee will be retroactively reinstated in the Plan as of the last day of active employment before leaving for active military service. The Employee will be responsible for payment of all back premium charges from the date Plan coverage terminated.

Cost of USERRA Continuation Coverage - The Employee must pay the cost of coverage (herein "premium"). The premium may not exceed 102% of the actual cost of coverage, and may not exceed the active Employee cost share if the military leave is less than 31 days. If the Employee fails to make timely payment within the same time period applicable to those enrollees of the plan continuing coverage under COBRA, the Plan Administrator will terminate the Employee's coverage at the end of the month for which the last premium payment was made. If the Employee applies for reinstatement to the Plan while still on active military service and otherwise meets the requirements of the Plan and of USERRA, the Plan Administrator will reinstate the Employee to Plan coverage retroactive to the last day premium was paid. The Employee will be responsible for payment of all back premium charges owed.

Maximum Period of Coverage - The maximum period of USERRA continuation coverage following Employee's cessation of active employment is the lesser of:

24 months; or

the duration of Employee's active military service.

Reinstatement of Coverage Following Active Duty - Regardless of whether an employee elects continuation coverage under USERRA, coverage will be reinstated on the first day the employee returns to active employment if the employee was released under honorable conditions.

An employee returning from military leave must notify their employer of their intent to return to work. Notification (application for reemployment) must be made:

within 14 days after active military service ceases for military leave of 31-180 days; or

within 90 days of completion of military service for military leave of more than 180 days.

No reemployment application is required if the military leave is less than 31 days. In that case, generally the employee need only report for work on the next regularly scheduled workday after a reasonable period for travel and rest. Uniformed Service members who are unable to report back to work because they are in the hospital or recovering from an injury or illness suffered during active duty have up to two (2) years to apply for reemployment.

When coverage hereunder is reinstated, all provisions and limitations of the Plan will apply to the extent that they would have applied if the employee had not taken military leave and coverage had been continuous. No waiting period can be imposed on a returning employee or Dependents if these exclusions would have been satisfied had the coverage not been terminated due to the order to active military service.

CLAIMS PROCEDURES

SUBMITTING A CLAIM

A claim is a request for a benefit determination that is made, in accordance with the Plan's procedures, by a Claimant or his authorized representative. A claim must name the Plan, a specific Claimant, a specific dental condition or symptom or diagnostic code, and a specific treatment, service or supply (or procedure/revenue codes) for which a benefit or benefit determination is requested, the date of service, the amount of charges, the address (location) where services are received, and provider name, address, phone number and tax identification number.

There are two types of dental claims: (1) Pre-Service Claims, and (2) Post-Service Claims:

1) **A Pre-Service Claim** is where the terms of the Plan condition benefits, in whole or in part, on prior approval of the proposed care. See the **Dental Pre-Treatment Estimate** section for that information.

   Important: A determination on a Pre-Service Claim is not a guarantee of benefits from the Plan. Plan benefit payments are subject to review upon submission of a claim to the Plan after dental services have been received, and are subject to all related Plan provisions, including exclusions and limitations.

2) **A Post-Service Claim** is a written request for benefit determination after a service has been rendered and expense has been incurred. A Post-Service Claim must be submitted to the claims office within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time.

   Written proof covering the details of loss for which a dental care claim is made must be furnished to the Contract Administrator within one (1) year of the date on which the expenses were incurred. Bills submitted after one (1) year will not be honored.

   A Post-Service Claim should be submitted as follows:

   eba&m – Employee Benefits Administration & Management Corporation
   P. O. Box 5079
   Westlake Village, CA 91359

ASSIGNMENTS TO PROVIDERS

All Eligible Expenses reimbursable under the Plan will be paid to the covered Employee except that: (1) assignments of benefits to providers of service will be honored, (2) the Plan may pay benefits directly to providers of service unless the Covered Person requests otherwise, in writing, within the time limits for filing a claim, and (3) the Plan may make benefit payments for a child covered by a Qualified Medical Child Support Order (a QMCSO) directly to the custodial parent or legal guardian of such child.

Benefits due to any Network provider will be considered "assigned" to such provider and will be paid directly to such provider, whether or not a written assignment of benefits was executed. Notwithstanding any assignment or non-assignment of benefits to the contrary, upon payment of the benefits due under the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.

No covered Employee or Dependent may, at any time, either while covered under the Plan or following termination of coverage, assign his right to sue to recover benefits under the Plan, or enforce rights due under the Plan or any other causes of action that he may have against the Plan or its fiduciaries.

NOTE: Benefit payments on behalf of a Covered Person who is also covered by a state's Medicaid program will be subject to the state's right to reimbursement for benefits it has paid on behalf of the Covered Person, as created by an assignment of rights made by the Covered Person or his beneficiary as may be required by the state Medicaid plan. Furthermore, the Plan will honor any subrogation rights that a state may have gained from a Medicaid-eligible beneficiary due to the state's having paid Medicaid benefits that were payable under the Plan.

CLAIMS TIME LIMITS AND ALLOWANCES

The chart below sets forth the time limits and allowances that apply to the Plan and a Claimant with respect to claims filings, administration and benefit determinations (i.e., how quickly the Plan will respond to claims notices, filings and claims appeals and how much time is allowed for Claimants to respond, etc.).

Important: These claims procedures address the periods within which claims determinations must be decided, not paid. Benefit payments must be made within reasonable periods of time following Plan approval, as governed by ERISA.

CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
Claimant Makes Initial Incomplete Claim Request	Within 30 days (and sooner if reasonably possible), Plan advises Claimant of information needed to complete the claim request. The Plan may extend this period for up to 15 days with full notice to the Claimant – see definition of "full notice" below.
Plan Receives Completing Information	Within 30 days, Plan approves or denies claim. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Makes Initial Complete Claim Request	Within 30 days of receiving the claim, Plan approves or denies claim. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Appeals	See "Appeals Procedures" subsection.
Plan Responds to Appeal	Within 60 days after receipt of appeal (or within 30 days for each appeal if Plan provides for two appeal levels).
"Full notice" means that notice is provided to the Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the initial 30-day or 60-day period.	

Authorized Representative May Act for Claimant
Any of the above actions that can be done by the Claimant can also be done by an authorized representative acting on the Claimant's behalf. The Claimant may be required to provide reasonable proof of such authorization.

Written or Electronic Notices
The Plan shall provide a Claimant with written or electronic notification of any benefit reduction or denial.

CLAIMS DENIALS

If a claim is wholly or partially denied (see NOTE), the Claimant will be given written or electronic notification of such denial within the time frames required by law (see **Claims Time Limits and Allowances**). The notice will include the following and will be provided in a manner intended to be understood by the Claimant:

the specific reason(s) for the decision to reduce or deny benefits:

specific reference to the Plan provision(s) on which the denial is based as well as identification of and access to any guidelines, rules, and protocols which were relied upon in making the decision;

a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records or other information relevant to the Claimant's claim for benefits;

a description of any additional information needed to change the decision and an explanation of why it is needed;

a description of the Plan's procedures and time limits for appealed claims, including a statement of the Claimant's right to bring a civil action under section 502(a) of ERISA.

APPEAL PROCEDURES

Filing an Appeal
Within 180 days of receiving notice of a claim reduction or denial, a Claimant may appeal his claim, in writing, to a new decision-maker and he may submit new information (comments, documents, records, etc.) in support of his appeal.

At such time as the Claimant appeals a denied claim, he will be provided, upon request and free of charge, with access to and copies of all documents, records and other information relevant to his claim for benefits. The Plan will also disclose the names of any dental professionals consulted as part of the claim process.

Decision on Appeal
A decision with regard to the claim appeal will be made within the allowed time frame (see **Claims Time Limits and Allowances**).

The decision on appeal will be in writing or by electronic notification. If the decision is to continue to reduce or deny benefits, the notification will be provided in a manner calculated to be understood by the Claimant and will include:

the specific reason(s) for the decision;

reference to the pertinent Plan provisions on which the decision is based;

a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim. The Plan will also disclose any documents that were created or received by the Plan during the appeal process;

identification of any experts whose advice was obtained in connection with the initial claim denial;

a statement describing any voluntary appeal procedures offered by the Plan, the Claimant's right to obtain the information about such procedures, and a statement of the Claimant's right to bring an action under ERISA section 502(a).

In accordance with Federal law, the Plan cannot require more than two (2) levels of mandatory appeal. If more than one (1) level of mandatory appeal is required, both must be completed within the time frame applicable to one (1) level.

DEFINITIONS

When capitalized within, the following items will have the meanings shown below.

Benefit Document – A document that describes one (1) or more benefits of the Plan.

Calendar Year - The period of time commencing at 12:01 A.M. on January 1 of each year and ending at 12:01 A.M. on the next succeeding January 1. Each succeeding like period will be considered a new Calendar Year.

Claimant - Any Covered Person for whom a claim is submitted for benefits under the Plan.

Contract Administrator - A company which performs all functions reasonably related to the general management, supervision and administration of the Plan in accordance with the terms and conditions of an administration agreement between the Contract Administrator and the Plan Sponsor.

Covered Person - An individual who meets the eligibility requirements as contained herein (e.g., a covered Employee/Retiree, a covered Dependent, a Qualified Beneficiary (COBRA), etc.). See **Eligibility and Effective Dates,** and the **Extensions of Coverage** sections for further information.

NOTE: In enrolling an individual as a Covered Person or in determining or making benefit payments to or on behalf of a Covered Person, the eligibility of the individual for state Medicaid benefits will not be taken into account.

Dentist - An individual who is duly licensed to practice dentistry or perform oral surgery in the state where the dental service is performed and who is operating within the scope of his license. A physician (M.D.) will be considered to be a Dentist when he performs any dental services within the operating scope of his license.

Dependent - see **Eligibility and Effective Dates** section

Eligible Expense(s) - Expense which is (1) covered by a specific benefit provision of the Benefit Document and (2) incurred while the person is covered by the Benefit Document.

Employee - see **Eligibility and Effective Dates** section

Employer(s) - The Employer or Employers participating in the Plan as stated in the **General Plan Information** section.

Fiduciary – An entity having binding power to make decisions regarding Plan policies, interpretations, practices or procedures.

Plan - The benefits described by the Plan Document or incorporated by reference and including any prior statement of the Plan. The name of the Plan is shown in the **General Plan Information** section.

Plan Administrator - see "Plan Sponsor"

Plan Document - A formal written document that describes the Plan and the rights and responsibilities of the Plan Sponsor with regard to the Plan, including any amendments.

Plan Sponsor - The entity sponsoring this Plan. The Plan Sponsor may also be referred to as the Plan Administrator. See **General Plan Information** section for further information.

Usual, Customary and Reasonable - A charge made by a provider which does not exceed the general level of charges made by other providers in the area or community who have similar experience and training for the treatment of dental conditions comparable in severity and nature to the dental condition being treated. The term "area" as it would apply to any particular service, medicine, or supply means a county or such greater area as is necessary to obtain a representative cross section of the level of charges.

NOTE: With regard to charges made by a provider of service participating in the Plan's Network program, Usual, Customary and Reasonable will mean the provider's negotiated rate.

GENERAL PLAN INFORMATION

Plan Sponsor:	**Garden Grove Unified School District**
Address:	10331 Stanford Avenue Garden Grove, CA 92840
Business Phone Number:	(714) 663-6523
Name of Plan:	**Garden Grove Unified School District Self-Insured Health Plan**
Plan Year:	**January 1 through December 31**
Plan Benefits:	**Dental Benefits**
Annual Re-Election Period:	**October**
Contract Administrator:	**EBA&M**
Billing Address:	P. O. Box 5079 Westlake Village, CA 91359
Phone:	(800) 249-8440
Facsimile:	(714) 546-0161

FUNDING - SOURCES AND USES

Employee & Employer Obligations
Plan benefits are paid from the general assets of the Plan Sponsor. The Plan Administrator shall, from time to time, evaluate and determine the amount to be contributed, if any, by each Employee or Plan participant.

COBRA costs are fully the Employee's or Qualified Beneficiary's responsibility and are generally 102% of the full cost of coverage for active (NonCOBRA) enrollees, except in special circumstances where a greater cost is allowed by law.

For active Employees, the Employee's share of the cost(s) will be deducted on a regular basis from his wages or salary. In other instances, the Employee or Plan participant will be responsible for remitting payment to the Employer in a timely manner as prescribed by the Employer.

Taxes
Any premium or other taxes which may be imposed by any state or other taxing authority and which are applicable to the coverages of the Plan will be paid by the Plan Sponsor.

ADMINISTRATIVE PROVISIONS

Administration (type of)
Certain benefits of the Plan are administered by a Contract Administrator under the terms and conditions of administration agreement(s) between the Plan Sponsor and Contract Administrator. The Contract Administrator is not an insurance company.

Amendment or Termination of the Plan
Since future conditions affecting the Plan Sponsor or Employer(s) cannot be anticipated or foreseen, the Plan Sponsor must necessarily and does hereby reserve the right to, without the consent of any participant or beneficiary:

determine eligibility for benefits or to construe the terms of the Plan;

alter or postpone the method of payment of any benefit;

amend any provision of these administrative provisions;

make any modifications or amendments to the Plan as are necessary or appropriate to qualify or maintain the Plan as a plan meeting the requirements of the applicable sections of the Internal Revenue Code or applicable law; and

terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time and on a retroactive basis, if necessary, provided, however, that no modification or amendment shall divest an Employee of a right to those benefits to which he has become entitled under the Plan.

NOTE: Any modification, amendment or termination action will be done in writing, and by resolution of a majority of the Plan Sponsor's board of directors, or by written amendment that is signed by at least one Fiduciary of the Plan. Employees will be provided with notice of the change within the time allowed by federal law.

Anticipation, Alienation, Sale or Transfer
Except for assignments to providers of service (see **Claims Procedures** section), no benefit payable under the provisions of the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge will be void; nor will such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of, or claims against, any Employee, covered Dependent or beneficiary, including claims of creditors, claims for alimony or support, and any like or unlike claims.

Clerical Error
Clerical error by the Employer or Plan Sponsor will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

Discrepancies
In the event that there may be a discrepancy between any separate booklet(s) provided to Employees ("Summary Plan Descriptions") and the Benefit Document, the Benefit Document will prevail.

Entire Contract
The Benefit Document, any amendments, and the individual applications, if any, of Covered Persons will constitute the entire contract between the parties. The Plan does not constitute a contract of employment or in any way affect the rights of an Employer to discharge any Employee.

Facility of Payment
Every person receiving or claiming benefits under the Plan will be presumed to be mentally and physically competent and of age. However, in the event the Plan determines that the Employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Employee has not provided the Plan with an address at which he can be located for payment, the Plan may, during the lifetime of the Employee, pay any amount otherwise payable to the Employee, to the husband or wife or relative by blood of the Employee, or to any other person or institution determined by the Plan to be equitably entitled thereto; or in the case of the death of the Employee before all amounts payable have been paid, the Plan may pay any such amount to one or more of the following surviving relatives of the Employee: lawful spouse, child or children, mother, father, brothers, or sisters, or the Employee's estate, as the Plan Sponsor in its sole discretion may designate. Any payment in accordance with this provision will discharge the obligation of the Plan.

If a guardian, conservator or other person legally vested with the care of the estate of any person receiving or claiming benefits under the Plan is appointed by a court of competent jurisdiction, payments will be made to such guardian or conservator or other person, provided that proper proof of appointment is furnished in a form and manner suitable to the Fiduciaries. To the extent permitted by law, any such payment so made will be a complete discharge of any liability therefore under the Plan.

Fiduciary Responsibility, Authority and Discretion
Fiduciaries will serve at the discretion of the Plan Sponsor and will serve without compensation for such services, but they will be entitled to reimbursement of their expenses properly and actually incurred in an official capacity. Fiduciaries will discharge their duties under the Plan solely in the interest of the Employees and their beneficiaries and for the exclusive purpose of providing benefits to Employees and their beneficiaries and defraying the reasonable expenses of administering the Plan.

The Fiduciaries will administer the Plan and will have the authority to exercise the powers and discretion conferred on them by the Plan and will have such other powers and authorities necessary or proper for the administration of the Plan as may be determined from time to time by the Plan Sponsor.

In carrying out their responsibilities under the Plan, Fiduciaries will have discretionary authority to interpret the terms of the Plan and Plan Document, even if the terms are found to be ambiguous, and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Fiduciaries may employ such agents, attorneys, accountants, investment advisors or other persons (who also may be employed by the Employer) or third parties (such as, but not limited to provider networks or utilization review organizations) as in their opinion may be desirable for the administration of the Plan, and may pay any such person or third party reasonable compensation. The Fiduciaries may delegate to any agent, attorney, accountant or other person or third party selected by them, any power or duty vested in, imposed upon, or granted to them by the Plan.

However, Fiduciaries will not be liable for acts or omissions of any agent, attorney, accountant or other person or third party except to the extent that the appointing Fiduciaries violated their own general fiduciary duties in: (1) establishing or implementing the Plan procedures for allocation or delegation, (2) allocating or delegating the responsibility, or (3) continuing the allocation or delegation.

Force Majeure
Should the performance of any act required by the Plan be prevented or delayed by reason of any act of nature, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties will use reasonable efforts to perform their respective obligations under the Plan.

Gender and Number
Except when otherwise indicated by the context, any masculine terminology will also include the feminine (and vice-versa) and any term in the singular will also include the plural (and vice-versa).

Illegality of Particular Provision
The illegality of any particular provision of the Benefit Document will not affect the other provisions, but the Benefit Document will be construed in all respects as if such invalid provision were omitted.

Indemnification
To the extent permitted by law, Employees of the Employer, the Fiduciaries, and all agents and representatives of the Fiduciaries will be indemnified by the Plan Sponsor and saved harmless against any claims and conduct relating to the administration of the Plan except claims arising from gross negligence, willful neglect, or willful misconduct. The Plan Sponsor reserves the right to select and approve counsel and also the right to take the lead in any action in which it may be liable as an indemnitor.

Legal Actions
No Employee, Dependent or other beneficiary will have any right or claim to benefits from the Plan, except as specified herein. Any dispute as to benefits under this Plan will be resolved by the Plan Sponsor under and pursuant to the Benefit Document and Plan Document.

No legal action may be brought to recover on the Plan: (1) more than three years from the time written proof of loss is required to be given, or (2) until the Plan's mandatory claim appeal(s) are exhausted. See the **Claims Procedures** section for more information.

Loss of Benefits
To the extent permitted by law, the following circumstances may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, offset, reduction or recovery of any benefit that a Plan participant or beneficiary might otherwise reasonably expect the Plan to provide based on the description of benefits:

an employee's cessation of active service for the employer;

a Plan participant's failure to pay his share of the cost of coverage, if any, in a timely manner;

a dependent ceases to meet the Plan's eligibility requirements (e.g., a child reaches a maximum age limit or a spouse divorces);

a Plan participant is injured and expenses for treatment may be paid by or recovered from a third party;

a claim for benefits is not filed within the time limits of the Plan.

Material Modification
In the case of any modification or change to the Plan that is a "material reduction in covered services or benefits," Plan participants and beneficiaries are to be furnished a summary of the change not later than sixty (60) days after the adoption of the change. This does not apply if the Plan Sponsor provides summaries of modifications or changes at regular intervals of not more than ninety (90) days. "Material modifications" are those that would be construed by the average Plan participant as being "important" reductions in coverage.

Misstatement / Misrepresentation
If the marital status, Dependent status or age of a Covered Person has been misstated or misrepresented in an enrollment form and if the amount of the contribution required with respect to such Covered Person is based on such criteria, an adjustment of the required contribution will be made based on the Covered Person's true status.

If marital status, Dependent status or age is a factor in determining eligibility or the amount of a benefit and there has been a misstatement of such status with regard to an individual on an enrollment form or claims filing, his eligibility, benefits or both, will be adjusted to reflect his true status.

A misstatement of marital status, Dependent status or age will void coverage not validly in force and will neither continue coverage otherwise validly terminated nor terminate coverage otherwise validly in force. The Plan will make any necessary adjustments in contributions, benefits or eligibility as soon as possible after discovery of the misstatement or misrepresentation. The Plan will also be entitled to recover any excess benefits paid or receive any shortage in contributions required due to such misstatement or misrepresentation.

Misuse of Identification Card
If an Employee or covered Dependent permits any person who is not a covered member of the family unit to use any identification card issued, the Plan Sponsor may give Employee written notice that his (and his family's) coverage will be terminated at the end of thirty-one (31) days from the date written notice is given.

Purpose of the Plan
The purpose of the Plan is to provide certain dental benefits for eligible Employees of the Participating Employer(s) and their eligible Dependents.

Reimbursements
Plan's Right to Reimburse Another Party - Whenever any benefit payments that should have been made under the Plan have been made by another party, the Plan Sponsor and the Contract Administrator will be authorized to pay such benefits to the other party; provided, however, that the amounts so paid will be deemed to be benefit payments under the Plan, and the Plan will be fully discharged from liability for such payments to the full extent thereof.

Plan's Right to be Reimbursed for Payment in Error - When, as a result of error, clerical or otherwise, benefit payments have been made by the Plan in excess of the benefits to which a Claimant is entitled, the Plan will have the right to recover all such excess amounts from the Employee, or any other persons, insurance companies or other payees, and the Employee or Claimant will make a good faith attempt to assist in such repayment. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from the Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

Plan's Right to Recover for Claims Paid Prior to Final Determination of Liability - The Plan Sponsor may, in its sole discretion, pay benefits for care or services pending a determination of whether or not such care or services are covered hereunder. Such payment will not affect or waive any exclusion, and to the extent benefits for such care or services have been provided, the Plan will be entitled to recoup and recover the amount paid therefore from the Covered Person or the provider of service in the event it is determined that such care or services are not covered. The Covered Person (parent, if a minor) will execute and deliver to the Plan Sponsor or the Contract Administrator all assignments and other documents necessary or useful for the purpose of enforcing the Plan's rights under this provision. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

Rights Against the Plan Sponsor or Employer
Neither the establishment of the Plan, nor any modification thereof, nor any distributions hereunder, will be construed as giving to any Employee or any person any legal or equitable rights against the Plan Sponsor, its shareholders, directors, or officers, or as giving any person the right to be retained in the employ of the Employer.

Titles or Headings
Where titles or headings precede explanatory text throughout the Benefit Document, such titles or headings are intended for reference only. They are not intended and will not be construed to be a substantive part of the Benefit Document and will not affect the validity, construction or effect of the Benefit Document provisions.

Type of Plan
This is an employee welfare benefit plan whose purpose is to provide certain welfare benefits for eligible Employees of the Employer(s) and their eligible Dependents.

This is a limited scope dental plan and is excepted from the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as that act applies to health status discrimination in eligibility.

Workers' Compensation
The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or similar legislation.

STATEMENT OF RIGHTS

Plan participants are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that a Plan participant shall be entitled to:

Receive Information About His/Her Plan and Benefits. This includes the right to:

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

obtain, upon written request to the Plan Administrator, copies of documents governing the operation of a Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies. Where permitted by law, these documents may be provided electronically; and

receive a summary of a Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage. This includes:

the right to continue health care coverage for himself/herself, spouse or dependents if there is a loss of coverage under a Plan as a result of a Qualifying Event. The employee or his/her dependents may have to pay for such coverage; and

reduction or elimination of exclusionary periods of coverage for preexisting conditions under a Plan, if he/she has creditable coverage from another plan. An individual should be provided a certificate of creditable coverage, free of charge, from his/her group health plan or health insurance issuer when he/she loses coverage under a plan if he/she requests it before losing coverage or if he/she requests it up to 24 months after losing coverage. Without evidence of creditable coverage, he/she may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after his/her enrollment date in the Plan.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of a Plan (the fiduciaries). Fiduciaries have a duty to operate a Plan prudently and in the interest of Plan participants and beneficiaries. No one, including the employer, may fire a Plan participant or discriminate against him/her to prevent him/her from obtaining a welfare benefit or exercising rights under ERISA.

If an individual's claim for a welfare benefit is denied in whole or in part, he/she must receive a written explanation of the reason for the denial. He/she has the right to have the Plan Administrator review and reconsider his/her claim.

Enforce His/Her Rights

Under ERISA there are steps a Plan participant can take to enforce the above rights. For instance, if he/she requests materials from a Plan and does not receive them within 30 days, he/she may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay him/her up to $110 a day until he/she receives the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If he/she has a claim for benefits which is denied or ignored, in whole or in part, he/she may file suit in a state or Federal court. In addition, if he/she disagrees with the Plan decision or lack thereof, concerning the qualified status of a medical child support order (QMCSO), he/she may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if he/she is discriminated against for asserting his/her rights, he/she may seek assistance from the U.S. Department of Labor, or he/she may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If he/she is successful, the court may order the person he/she has sued to pay these costs and fees. If he/she loses, the court may order him/her to pay these costs and fees, for example, if it finds his/her claim is frivolous.

Assistance With His/Her Questions

If a Plan participant has any questions about a Plan, he/she should contact the Plan Administrator. If he/she has any questions about this statement or about his/her rights under ERISA, he/she should contact: (1) the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor as listed in his/her telephone directory, or (2) the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. A Plan participant may also obtain certain publications about his/her rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ADOPTION OF THE BENEFIT DOCUMENT

Adoption
The Plan Sponsor hereby adopts this Benefit Document on the date shown below. This Benefit Document replaces any and all prior statements of the Plan benefits that are described herein.

Purpose of the Plan
The purpose of the Plan is to provide certain dental benefits for eligible Employees of the Participating Employer(s) and their eligible Dependents. The benefits provided by the Plan are as listed in the **General Plan Information** section.

Conformity with Law
If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to such law.

Participating Employers
Employers participating in this Plan are as stated in the section entitled **General Plan Information**.

The Plan Sponsor may act for and on behalf of any and all of the Participating Employers in all matters pertaining to the Plan, and every act, agreement, or notice by the Plan Sponsor will be binding on all such Employers.

Acceptance of the Benefit Document
IN WITNESS WHEREOF, the Plan Sponsor has caused this instrument to be executed, effective as of January 1, 2017.

Garden Grove Unified School District

By: _____

Title: _____