

Group voluntary dental insurance benefit summary for

all members

Effective date: 01/01/2021

What's available to me?

Dental insurance helps pay for all, or a portion, of the costs associated with dental care, from routine cleanings to root canals.

Combined annual benefit maximum

This is the total amount your insurance will cover annually for all services combined.

Combined annual benefit maximum - all	
In-network	Out-of-network
\$1,500	\$1,500

Preventive

Calendar year deductible		Coinsurance your policy pays	
In-network	Out-of-network	In-network	Out-of-network
\$0	\$0	100%	100%

- Routine exams - twice per calendar year
- Routine cleanings - twice per calendar year
- Bitewing X-rays - once per calendar year
- Fluoride – once per calendar year (covered only for dependent children under age 14)

Basic

Calendar year deductible		Coinsurance your policy pays	
In-network	Out-of-network	In-network	Out-of-network
\$50	\$50	80%	80%

- Full mouth X-rays – once every 60 months
- Sealants – covered only for dependent children under age 14 once per tooth each 36 months
- Emergency exams – subject to Routine exam frequency limit
- Periodontal maintenance - if three months have passed since active surgical periodontal treatment; subject to Routine cleaning frequency limit
- Fillings - covered once every 24 months

Major

Calendar year deductible	Coinsurance your policy pays
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In-network	Out-of-network	In-network	Out-of-network
\$50	\$50	50%	50%

- Simple oral surgery
- Complex oral surgical procedures
- General anesthesia / IV sedation (covered only for specific procedures)
- Simple endodontics (root canal therapy for anterior teeth)
- Complex endodontics (root canal therapy for molar teeth)
- Non-surgical periodontics, including scaling and root planing - once per quadrant per 24 months
- Periodontal surgical procedures - once per quadrant per 36 months
- Crowns – each 120 months per tooth
- Core buildup - each 120 months per tooth
- Bridges (initial placement / replacement) - 120 months old
- Dentures (initial placement / replacement) - 60 months old

### Orthodontia

Calendar year deductible		Coinsurance your policy pays		Lifetime maximum	
In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
\$0	\$0	50%	50%	\$1,500	\$1,500

- Child coverage
- Bands that are placed on a dependent child's teeth before age 19 may be covered.

### Additional benefits

- Family deductible - 3 times the per person deductible amount
- Combined deductible - Your deductibles that are in-network for basic and major services are combined. Your deductibles that are out-of-network for basic and major services are combined.
- Prevailing charge - When you receive care from an out-of-network-provider, benefits will be based on the 90<sup>th</sup> percentile of the usual and customary charges.
- Maximum accumulation – Some of your unused annual benefit maximum can be carried over to the next year. To qualify, you must have had a dental service performed within the calendar year and used less than the maximum threshold. The threshold is equal to the lesser of 50% of the out-of-network maximum benefit or \$1,000. If the qualification is met, 50% of the threshold is carried over to next year's maximum benefit. Individuals with fourth quarter effective dates will start qualifying for rollover at the beginning of the next calendar year. You can accumulate no more than four times the carry over amount. The entire accumulation amount will be forfeited if no dental service is submitted within a calendar year.
- Periodontal program - If you're pregnant or have diabetes or heart disease, you may receive scaling and root planing covered at 100% (if dentally necessary), or one additional cleaning (routine or periodontal) subject to deductible and coinsurance.
- Second opinion program - You may be eligible for second opinions from dental providers at 100%. This program makes sure you get the best advice to make an informed decision about your care.

- Cancer treatment oral health program - If you have cancer and are undergoing chemotherapy or head/neck radiation therapy, you may receive up to three fluoride treatments every 12 months covered at 100% plus one additional routine cleaning.

There are additional limitations to your coverage. A complete list is included in your booklet.

### Who can buy coverage?

- You may buy coverage if you're an active, full-time employee working at least 30 hours a week. Seasonal, temporary, or contract employees can't purchase.
  - o If you're on regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off, you're still considered actively at work, as long as you're fulfilling your regular duties and were working the day immediately prior to your time off.
  - o You must enroll within 31 days of being eligible. If you don't, you'll have to wait until the next open enrollment period, or qualifying event.

Additional eligibility requirements may apply.

### How do I find a network dentist?

When you receive services from a dentist in our network, your cost may be lower. Network dentists agree to lower their fees for dental services and not charge you the difference. You'll have access to the Principal Plan Dental network, with more than 117,000 dentists nationwide. Visit [principal.com/dentist](http://principal.com/dentist) to find a dentist or call 800-247-4695.

### What if my dentist isn't in the network?

You can refer your dentist to our network. Please submit the dentist's name and information by calling 800-832-4450, or submitting a form at [principal.com/refer-dental-provider](http://principal.com/refer-dental-provider).

### What are the limitations and exclusions of my coverage?

- Missing tooth –The initial placement of bridges, partials, and dentures to replace teeth missing before this coverage starts won't be covered. If this policy replaces coverage with another carrier, continuous coverage under the prior plan may be applied to the missing tooth provision requirement. This doesn't apply to pediatric essential benefits.
- Frequency limitations for services are calculated to the month and exact date from the last date of service or placement date.

There are additional limitations to your coverage. Please review your booklet for more information.

## What are the restrictions of my coverage?

### Orthodontia

If there is orthodontia (ortho) treatment in progress on the coverage effective date and you are covered under any prior group coverage for ortho, there will be immediate coverage for treatment if proof is submitted that shows:

- 1) The lifetime maximum under any prior group coverage has not been exceeded,
- 2) Ortho treatment was started and bands or appliances were inserted while insured under any prior group coverage, and
- 3) Ortho treatment has been continued while insured under this policy.

Principal Life will credit payments made by the prior carrier toward the Principal Life lifetime ortho payment limit.

You will not be covered if ortho treatment is in progress prior to the effective date with Principal Life and you are not covered under any prior group coverage for ortho.

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This is a summary of dental coverage insured by or with administrative services provided by Principal Life Insurance Company. This outline is a brief description of your coverage. It is not an insurance contract or a complete statement of the rights, benefits, limitations and exclusions of the coverage. If there is a discrepancy between the policy and this document, the actual policy provision prevails. For complete coverage details, refer to the booklet.

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