

## Policyholder: GENESIS 10

### Group dental insurance Benefit summary

Effective date: 11/01/2023

#### 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.

Eligibility				
Eligible employees	All active, full-time employees			
Calendar-year deductible			Coinsurance your policy pays	
Option 1 (internal staff elect basic plan)				
	In-network	Out-of-network	In-network	Out-of-network
Preventive	\$0	\$0	100%	100%
Basic	\$0	\$0	80%	80%
Additional provisions				
Combined maximum	Maximums for preventive and basic procedures are combined. In-network calendar year maximums are \$500 per person or non-network calendar year maximums are \$500 per person.			
Plan type	Unscheduled			
Calendar-year deductible			Coinsurance your policy pays	
Option 2 (internal staff elect full plan)				
	In-network	Out-of-network	In-network	Out-of-network
Preventive	\$0	\$0	100%	90%
Basic	\$50	\$50	90%	80%
Major	\$50	\$50	60%	50%
Orthodontia	\$0	\$0	50%	50%
Additional provisions				
Family deductible	3 times the per person deductible amount			
Combined deductible	Your deductibles that are in and out-of-network for services are combined.			
Combined maximum	Maximums for preventive, basic, and major procedures are combined. In-network calendar year maximums are \$1,000 per person or non-network calendar year maximums are \$1,000 per person.			

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Orthodontia lifetime maximum	\$1,000 PPO in-network maximum / \$1,000 PPO out-of-network maximum
Maximum accumulation	Included
Plan type	Unscheduled

### Who can buy coverage?

- You may buy coverage if you're an active, full-time employee. Seasonal, temporary, or contract employees aren't eligible.
  - 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.
  - 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.

### Which procedures are covered, and how often?

#### Option 1

Preventive	
Routine exams	Twice per calendar year
Routine cleanings	Twice per calendar year
Bitewing X-rays	Once per calendar year
Full mouth X-rays	Once every 60 months
Fluoride	Once per calendar year (covered only for dependent children under age 14)
Basic	
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	Replacement fillings every 24 months
Harmful habit appliance	Covered only for dependent children under age 14

### Additional benefits

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.
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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.
General anesthesia program	If you have autism, Down syndrome, cerebral palsy, muscular dystrophy, or spina bifida you may receive general anesthesia or intravenous sedation coverage. Services must be administered in a dental office. All other contractual limitations apply.

## Option 2

Preventive	
Routine exams	Twice per calendar year
Routine cleanings	Twice per calendar year
Bitewing X-rays	Once per calendar year
Full mouth X-rays	Once every 60 months
Fluoride	Once per calendar year (covered only for dependent children under age 16)
Sealants	Covered only for dependent children under age 16; once per tooth each 36 months
Emergency exams	Subject to routine exam frequency limit
Harmful habit appliance	Covered only for dependent children under age 16
Basic	
Periodontal maintenance	If three months have passed since active surgical periodontal treatment; subject to Routine cleaning frequency limit
Fillings	Replacement fillings every 24 months
Oral surgery	Simple and complex
General anesthesia / IV sedation	Covered for only 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

Major	
Periodontal surgical procedures	Once per quadrant per 36 months
Crowns	Each 60 months per tooth if tooth cannot be replaced by a filling
Core buildup	Each 60 months
Bridges	60 months old (initial placement / replacement)
Dentures	60 months old (initial placement / replacement)
Repairs	Partial denture, bridge, crown, relines, rebasing, tissue conditioning and adjustment to bridge/denture, within policy limitations
Orthodontia	
Coverage	For your dependent children. Bands that are placed on a dependent child's teeth before age 19 may be covered.

### Additional benefits

Prevailing charge	When you receive care from an out-of-network-provider, benefits will be based on the 80 <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.
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**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](https://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 800-247-4695, or submitting a form at [principal.com/refer-dental-provider](https://principal.com/refer-dental-provider).

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

- Missing tooth provision –This means the initial placement of bridges, partials, dentures, and implant services to replace teeth missing before this coverage starts may not be covered. If the policy your employer purchased replaces coverage with another carrier, continuous coverage under the prior plan may be applied and you may be eligible for coverage to replace teeth missing before this coverage started. Your effective date with your current employer, along with the employer's effective date with Principal are used to determine coverage. Missing tooth provision 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. We strongly recommend submitting a predetermination to determine benefits.

**What are the restrictions of my coverage?**

Orthodontia	<p>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:</p> <ol style="list-style-type: none"><li>1) Ortho treatment was started and bands or appliances were inserted while insured under any prior group coverage, and</li><li>2) Ortho treatment has been continued while insured under this policy.</li></ol> <p>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.</p>
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There are additional limitations to your coverage. A complete list is included in your booklet.



[principal.com](https://principal.com)

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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