Principal Dental Premiums, Effective 4/1/2023

Rates

Rates / Class Tier	Dental Rates	
	Plan 1 DPPO (High)	Plan 2 DPPO (Low)
Employee only	$44.73	$25.11
Employee + spouse	$89.53	$48.82
Employee + 1 child	$89.53	$48.82
Employee & 2+ child(ren)	$118.33	$64.36
Employee + family	$118.33	$64.36

Deductibles, out-of-pocket totals, copays, and dental benefits vary by plan. Please pay close attention to the details as you make your selection. The lowest monthly premium may not be the best choice.

Principal®

Policyholder: MUSIC INSTITUTE OF CHICAGO

Voluntary Dental PPO Benefit Summary

Predetermination of Benefits: Before treatment begins for inlays, onlays, single crowns, prosthetics, periodontics and oral surgery, you may file a dental treatment plan with Principal Life Insurance Company. Principal Life will provide a written response indicating benefits that may be payable for the proposed treatment.

This chart provides you a brief summary of the key benefits of the dental coverage available from Principal Life Insurance Company. Following the chart, you will find additional information to answer questions you may have. For a complete list of all your dental coverage benefits and restrictions, please refer to your booklet or contact your employer.

Eligibility	
Benefit Choice	Eligible members may select ONE OF THE TWO BENEFIT OPTIONS outlined below

Option 1 (High Plan)

Benefits Payable				
Job Class	MBRS ELECT HIGH DEN PLAN			
Network	Dental Preferred Provider Organization (PPO)			
Network Service Area	Illinois			
	Calendar Year Deductible		**Coinsurance (Policy Pays)**	
	In-Network	**Non-Network**	**In-Network**	**Non-Network**
Unit 1 – Preventive	$0	$0	100%	100%
Unit 2 – Basic	$0	$75	80%	80%
Unit 3 – Major	$50	$75	50%	50%
Family Deductible Maximum	2 times the per person deductible amount			
Combined Deductible	Non-network deductibles for basic and major procedures are combined.			
Combined Maximums	Maximums for preventive, basic, and major procedures are combined. In-network Calendar year maximums are $1,000 per person. Non-network Calendar year maximums are $1,000 per person.			
Maximum Accumulation	This allows for a portion of unused maximum benefit to carry over to next year's maximum benefit amount. 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 maximum benefit or $1000. If qualification is met, 50% of the threshold is carried over to next year's maximum benefit. Individuals with fourth quarter effectives 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.			
Emergency Services	If a member requires treatment or service for an emergency dental condition and cannot reach a preferred dental provider without unreasonable delay, benefits for such treatment or service received from a non-preferred dental provider will be paid as if the treatment or service had been provided by a preferred dental provider. The member must provide information either with the claim or during an appeal that identifies the situation as an emergency.			

Participating Provider Services	If a member requires treatment or service and cannot reasonably reach a preferred dental provider and the member receives such treatment or service from a non-preferred dental provider, benefits for such treatment or service received will be paid as if the treatment or service had been provided by a preferred dental provider. The member must provide information either with the claim or during an appeal that informs Principal Life there was no participating provider reasonably available.

How Are Dental Procedures Covered Under Option 1?

The list of common procedures shows what unit the procedure is included in and how often they are covered.

Unit 1 – Preventive Procedures	• Routine exams - one per six months • Routine cleaning (prophylaxis) - one per six months (Expectant mothers, diabetics and those with heart disease receive one additional routine or periodontal cleaning.) • Second Opinion Consultation • Fluoride – one treatment each calendar year (covered only for dependent children under age 19) • Space maintainers - covered only for dependent children under age 19; repairs not covered • Sealants – on first and second permanent molars for dependent children under age 19; one each tooth each 36 months
Unit 2 – Basic Procedures	• Periodontal prophylaxis - if three months have elapsed after active surgical periodontal treatment;one per six months (Expectant mothers, diabetics and those with heart disease receive one additional routine or periodontal cleaning.) • Emergency exams – subject to Routine exam frequency limit • Harmful Habit Appliance - covered only for dependent children under age 19 • X-rays - Bitewing (one set every calendar year), occlusal, periapical • X-rays – Full mouth survey (one every 60 months), extraoral • Fillings and stainless steel crowns
Unit 3 – Major Procedures	• General Anesthesia (covered only for specific procedures)/IV Sedation • Simple Oral Surgery • Complex Oral Surgical Procedures • Non-surgical Periodontics, including scaling and root planing - once each quadrant each 24 months (For expectant mothers, diabetics and those with heart disease, this procedure is provided with no deductible and 100% coinsurance.) • Periodontal Surgical Procedures – one each quadrant each 36 months • Simple Endodontics (root canal therapy for anterior teeth) • Complex Endodontics (root canal therapy for molar teeth) • Repairs to Partial Denture, Bridge, Crown, Relines, Rebasing, Tissue Conditioning and Adjustment to Bridge/Denture, within policy limitations • Crowns – each 120 months per tooth if tooth cannot be restored by a filling. • Inlays, Onlays, Cast Post and Core, Core Buildup - each 120 months per tooth • Bridges - Initial placement / Replacement of bridges 120 months old. • Dentures - Initial placement of complete or partial dentures / Replacement of complete or partial dentures over 60 months old

There is Coordination of Benefits, which is a procedure for limiting benefits from two or more carriers to 100% of the claimant's covered expenses.

Option 2 (Low plan)

Benefits Payable				
Job Class	MBRS ELECT LOW DEN PLAN			
Network	Dental Preferred Provider Organization (PPO)			
Network Service Area	Illinois			
	Calendar Year Deductible		**Coinsurance (Policy Pays)**	
	In-Network	Non-Network	In-Network	Non-Network
Unit 1 – Preventive	$0	$300	100%	10%
Unit 2 – Basic	$50	$300	80%	10%
Unit 3 – Major	$50	$300	50%	10%
Family Deductible Maximum	3 times the per person deductible amount			
Combined Deductible	In-network deductibles for basic and major procedures are combined.			
Combined Maximums	Maximums for preventive, basic, and major procedures are combined. In-network Calendar year maximums are $1,000 per person. Non-network Calendar year maximums are $1,000 per person.			
Maximum Accumulation	This allows for a portion of unused maximum benefit to carry over to next year's maximum benefit amount. 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 maximum benefit or $1000. If qualification is met, 50% of the threshold is carried over to next year's maximum benefit. Individuals with fourth quarter effectives 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.			
Emergency Services	If a member requires treatment or service for an emergency dental condition and cannot reach a preferred dental provider without unreasonable delay, benefits for such treatment or service received from a non-preferred dental provider will be paid as if the treatment or service had been provided by a preferred dental provider. The member must provide information either with the claim or during an appeal that identifies the situation as an emergency.			
Participating Provider Services	If a member requires treatment or service and cannot reasonably reach a preferred dental provider and the member receives such treatment or service from a non-preferred dental provider, benefits for such treatment or service received will be paid as if the treatment or service had been provided by a preferred dental provider. The member must provide information either with the claim or during an appeal that informs Principal Life there was no participating provider reasonably available.			

How Are Dental Procedures Covered Under Option 2?

The list of common procedures shows what unit the procedure is included in and how often they are covered.

Unit 1 – Preventive Procedures	• Routine exams - one per six months • Routine cleaning (prophylaxis) - one per six months (Expectant mothers, diabetics and those with heart disease receive one additional routine or periodontal cleaning.) • Second Opinion Consultation • Fluoride – one treatment each calendar year (covered only for dependent children under age 19) • X-rays - Bitewing (one set every calendar year), occlusal, periapical • X-rays – Full mouth survey (one every 60 months), extraoral
Unit 2 – Basic Procedures	• Periodontal prophylaxis - if three months have elapsed after active surgical periodontal treatment; one per six months (Expectant mothers, diabetics and those with heart disease receive one additional routine or periodontal cleaning.) • Emergency exams – subject to Routine exam frequency limit • Space maintainers - covered only for dependent children under age 19; repairs not covered • Sealants – on first and second permanent molars for dependent children under age 19; one each tooth each 36 months • Harmful Habit Appliance - covered only for dependent children under age 19 • Fillings and stainless steel crowns • Composite fillings on molars • Simple Oral Surgery • Non-surgical Periodontics, including scaling and root planing - once each quadrant each 24 months (For expectant mothers, diabetics and those with heart disease, this procedure is provided with no deductible and 100% coinsurance.) • Simple Endodontics (root canal therapy for anterior teeth)
Unit 3 – Major Procedures	• General Anesthesia (covered only for specific procedures)/IV Sedation • Complex Oral Surgical Procedures • Periodontal Surgical Procedures – one each quadrant each 36 months • Complex Endodontics (root canal therapy for molar teeth) • Repairs to Partial Denture, Bridge, Crown, Relines, Rebasing, Tissue Conditioning and Adjustment to Bridge/Denture, within policy limitations • Crowns – each 120 months per tooth if tooth cannot be restored by a filling. • Inlays, Onlays, Cast Post and Core, Core Buildup- each 120 per tooth • Bridges - Initial placement / Replacement of bridges 120 months old. • Dentures - Initial placement of complete or partial dentures / Replacement of complete or partial dentures over 60 months old

There is Coordination of Benefits, which is a procedure for limiting benefits from two or more carriers to 100% of the claimant's covered expenses.

Understanding Your Dental Benefits

Am I Eligible For Coverage?

To be eligible for coverage, you must qualify as an eligible member and be considered actively at work.

You must be enrolled for dental coverage before it can be offered to your dependents. Eligible dependents include your spouse (if not also enrolled as an employee) , qualified domestic partner and children, including those of your qualified domestic partner. Additional eligibility requirements may apply.

Open enrollment applies. Any employee or dependent that didn't enroll within 31 days of being eligible can only enroll during the open enrollment period.

How Do I Find A Participating Provider?

Use the Provider Directory on www.principal.com to locate nearby dentists or see if your dentist participates in your network.

1	Visit www.principal.com/dentist.
2	Begin your search by picking the **state** where you would like to find a provider. Next, specify a **network**. Depending on the network chosen, you may be transferred to a partner site.
3	Enter the **name of the provider** you are looking for (if known). If you are looking for a nearby dentist, enter the **city and state and/or ZIP code**. Be sure to indicate **how far you are willing to travel**.
4	Select the **desired specialty** or use the No Specialty Preference default. Click **Continue**.
5	Select a **language** if your preference is other than English. Click **Continue**.

You may nominate your dentist for inclusion in our network. Please submit the dentist's name, address, phone and specialty by calling 1-800-832-4450, or submit through www.principal.com/refer-dental-provider.

How Are Complaints Handled?

A “complaint” is a written communication primarily expressing a grievance and is filed by a consumer, a healthcare provider, or your representative either directly with Principal Life Insurance Company or via the Illinois Insurance Department. Complaints may be handwritten or typed and may be transmitted electronically, by facsimile, or by U.S. Mail.

Regulator complaints are first recorded by the corporate complaint register and forwarded to Group Life and Health Compliance for assignment to a complaint handler. Non-regulator complaints are handled by the Group Life & Health compliance department, the local claim service center, or the administration or underwriting department assigned to the consumer’s account.

Once a complaint is received, an acknowledgement letter is immediately sent identifying the name, address, and phone number of the person handling the complaint. An investigation is then made of the complaint. Within twenty-one (21) calendar days of the date of the Illinois Insurance Department's letter (or earlier, if specified by the Insurance Department), a substantive response is provided pursuant to instruction in the Illinois Insurance Department's cover letter. Within fifteen (15) working days from the receipt of a non-regulator complaint, a substantive response is provided to the complainant.

The response includes a description of how and when the consumer was covered with Principal Life, the policy provisions that govern the issues in question, what has transpired on the account, and an explanation of the decision either to uphold the original handling of the account or to take corrective action, why, and within what timing.

Principal Life maintains a complaint register that allows individual reconstruction of complaints as well as summary data.

What Are The Restrictions Of My Coverage?

This Benefit Summary is a summary only. For a complete list of benefit restrictions, please refer to your booklet.

Limitations & Exclusions	
Missing Tooth	Benefits for the initial placement of bridges, partials and dentures are not covered if those teeth were missing prior to becoming insured under the Principal Life policy. When the policy replaces coverage under a prior plan, continuous coverage under the prior plan may be applied to the missing tooth provision requirement.
Other Limitations	There are additional limitations to your coverage. A complete list is included in your booklet.

Principal Life Insurance Company, Des Moines, Iowa 50392-0002, www.principal.com

This is a summary of dental coverage underwritten by or with administrative services provided by Principal Life Insurance Company. This benefit summary is for administrative purposes and is not a complete statement of benefits and restrictions. You'll receive a benefit booklet with details about your coverage. If there is a discrepancy between this summary and your benefit booklet, the benefit booklet prevails.

eService

Go online to check your benefits

Keeping track of your benefits has never been easier

When you want information about your benefits from Principal®, simply go online. Best of all, this service is available at no charge.

How to create an online account

It's easy! We'll have you up and running in no time.

1 | Go to **principal.com**.

2 | Select **Log In,** then **Personal.**

3 | After selecting **Create an account,** enter personal information such as your date of birth and identification number.

4 | **Create a username** and password, and provide an email address.

You'll receive an email within a few minutes to confirm your account is ready to go. You can access your account information anytime, 24/7, with the username and password you've just set.

Manage your benefits online

After logging in, you can manage your benefits, as well as other products you may have with Principal. Your online account allows you to:

- View and manage claims (for applicable benefits)
- Get a 24-month history of your explanation of benefits (EOB)
- Access your summary of benefits, as well as benefit booklets and policies
- Find a list of covered dependents
- View and print your dental ID card
- Find discounts and services
- Calculate coverage needs and more

Keeping your account safe

Your information is important to us. And because of that, we use a security feature that prevents others from accessing your account – even if they have your password. Verification codes add an extra layer of security. The first time you log in, you'll **need to choose where you want us to send the verification codes – either by text or email.**

If you log in from an unrecognized computer or mobile phone, forget your password, or we notice anything out of the ordinary, these codes help us confirm it's really you accessing your account – not someone pretending to be you.

You can choose to receive these codes every time you log in or only when we detect unusual activity.

Principal®

Dental insurance

See the rewards of making healthy dental choices

Be prepared for big dental expenses with Maximum Accumulation

Like most of us, you know how important it is to take care of your teeth by getting regular dental check-ups. Preventive care can help you avoid the big stuff when it comes to your teeth. But it's not foolproof.

What happens when your dentist delivers the news that you need costly dental procedures? Dental insurance can be a big help financially, but there's a limit on how much it'll pay each calendar year. It's called your maximum benefit.

That's where Maximum Accumulation comes in.

How does Maximum Accumulation work?

You likely won't use all your maximum benefit every year. So where does that money go? If you visit your dentist during the year, you may be eligible to roll over a portion of your unused maximum benefit to increase your maximum benefit for the following year. It's available when you have dental coverage for preventive, basic and major services.

- **Preventive —** Exams, cleanings and sometimes x-rays
- **Basic —** X-rays, extractions, fillings and sometimes crowns
- **Major —** Crowns, inlays, onlays, bridges and dentures

How do you know if you're eligible to carry benefits over to the next year? If your dental claims are less than 50% of your annual maximum, you can roll over 25% and accumulate up to 1x your annual maximum. The amount accumulated is added to your annual maximum for the year.

Let's look at an example

	Calendar year maximum	Yearly claim limit	Benefits paid	Yearly rollover amount	Accumulated rollover amount	Total maximum available
Year 1	$1,000	$500	$450	$250	$250	$1,250
Year 2	$1,000	$500	$850	$0	$250	$1,250
Year 3	$1,000	$500	$450	$250	$500	$1,500
Year 4	$1,000	$500	$0	$0	$0	$1,000
Year 5	$1,000	$500	$450	$250	$250	$1,250

You can see that in year 2, where claims were more than the yearly claim limit — which is 50% of the maximum — there was no rollover. And in year 4, where there were no claims at all, your accumulated amount went back down to zero. That's why it pays to visit the dentist regularly for preventive care.

With Maximum Accumulation, you won't leave money for costly dental procedures on the table. See the rewards of making healthy choices for your teeth — all it takes is regularly visiting your dentist.