SUMMARY OF BENEFITS & RATES

Contributory Options PPO 20

Covered Dental Services · PPO Plan · Network: Principal Dental PPO

For demonstration purposes only. This document is a fictitious plan summary created for sales training and product demonstrations. It is not an offer of coverage, not an official carrier document, and does not reflect actual carrier rates or plan designs.

PRODUCT	PLAN TYPE	PLAN NAME	DEDUCTIBLE PERIOD
Dental	PPO	Contributory Options PPO 20	Calendar Year

INDIVIDUAL DEDUCTIBLE	FAMILY DEDUCTIBLE	ANNUAL MAXIMUM	ORTHODONTIC LIFETIME MAX
$50 / $50	$150 / $150	$1,500 / $1,500	$1,000 / $1,000

DEDUCTIBLES, MAXIMUMS & REIMBURSEMENT

COVERAGE FEATURE	NETWORK	NON-NETWORK
Individual Annual Deductible	$50	$50
Family Annual Deductible	$150	$150
Annual Maximum Benefit (per person)	$1,500	$1,500
Deductible Period	Calendar Year	
Out-of-Network Reimbursement Basis	Allowable Amount	

ANNUAL MAXIMUM ROLLOVER

Qualifying Claim Threshold	$500
Annual Rollover Amount	$350
In-Network Rollover Amount	$500
Rollover Account Maximum	$1,250

How it works: This plan includes an Annual Maximum Rollover benefit. When a covered person submits at least one qualifying claim in a plan year and total benefits paid do not exceed the qualifying threshold, a portion of the unused annual maximum rolls over into a Rollover Account, up to the Account Maximum.

INCLUDED PROGRAMS & FEATURES

Oral Cancer Screening
Included at no additional cost during routine exam.

Prenatal Dental Care
Additional cleaning and periodontal benefits during pregnancy. Not available in WA.

Teledentistry Consultations
Covered at the same level as in-person diagnostic visits.

Second Opinion Benefit
No-cost second consultation prior to major treatment.

COVERED SERVICES & COINSURANCE

SERVICE CATEGORY	NETWORK PLAN PAYS	NON-NETWORK PLAN PAYS
PREVENTIVE & DIAGNOSTIC SERVICES Deductible Applies: **No** · Counts Toward Annual Max: **Yes** · Waiting Period (Timely / Late): **None / None**		
• Periodic Oral Evaluation • Radiographs • Lab and Other Diagnostic Tests • Prophylaxis (Cleaning) • Fluoride Treatment (Preventive)	100%	100%
BASIC SERVICES Deductible Applies: **Yes** · Counts Toward Annual Max: **Yes** · Waiting Period (Timely / Late): **None / None**		
• Restorations, Amalgams or Composite (Anterior & Posterior) • Sealants • Space Maintainers • Emergency Treatment / General Services • Simple Extractions • Oral Surgery (incl. surgical extractions) • Periodontics	80%	80%
MAJOR SERVICES Deductible Applies: **Yes** · Counts Toward Annual Max: **Yes** · Waiting Period (Timely / Late): **None / 12 months**		
• Endodontics • Inlays / Onlays / Crowns • Dentures and Removable Prosthetics • Fixed Partial Dentures (Bridges)	50%	50%

ORTHODONTIC SERVICES

ADULT ELIGIBILITY **Yes**	CHILD ELIGIBILITY **Yes — through age 19 (through age 26 if full-time student)**	COINSURANCE — NETWORK **50%**
COINSURANCE — NON-NETWORK **50%**	LIFETIME MAX — NETWORK **$1,000**	LIFETIME MAX — NON-NETWORK **$1,000**
WAITING PERIOD — TIMELY ENTRANT **None**	WAITING PERIOD — LATE ENTRANT **12 months**	DEDUCTIBLE APPLIES **No**

FREQUENCIES & LIMITATIONS

SERVICE	FREQUENCY
Periodic Oral Evaluation	2 per 12 months
Prophylaxis (Cleaning)	2 per 12 months
Bitewing Radiographs	1 series per calendar year
Full-Mouth or Panorex Radiographs	1 per 36 months
Fluoride Treatment (under age 16)	2 per 12 months
Sealants (under age 16, 1st/2nd molars)	1 per tooth per 36 months
Crowns, Inlays, Onlays, Veneers	1 per tooth per 60 months
Full or Partial Dentures	1 per 60 months
Root Canal Therapy	1 per tooth per lifetime

MONTHLY PREMIUM RATES — CURRENT PLAN

TIER	MONTHLY RATE Composite rate per covered employee
Employee Only	**$35.23**
Employee + Spouse	**$89.56**
Employee + Child(ren)	**$87.56**
Family	**$135.00**

Rate basis: Rates shown are composite monthly premiums per contract. Contributions between employer and employee are determined at the group level.

GENERAL LIMITATIONS

- PERIODIC ORAL EVALUATION — Limited to 2 times per consecutive 12 months.
- COMPLETE SERIES OR PANOREX RADIOGRAPHS — Limited to 1 time per consecutive 36 months.
- BITEWING RADIOGRAPHS — Limited to 1 series per calendar year.
- DENTAL PROPHYLAXIS — Limited to 2 times per consecutive 12 months.
- FLUORIDE TREATMENTS — Covered persons under age 16; 2 times per consecutive 12 months.
- SEALANTS — Covered persons under age 16; 1st or 2nd permanent molar, once per 36 months.
- SPACE MAINTAINERS — Covered persons under age 16; 1 per consecutive 60 months.
- RESTORATIONS — Multiple restorations on one surface are treated as a single filling.
- INLAYS, ONLAYS & VENEERS — 1 per tooth per consecutive 60 months; covered only when a filling cannot restore the tooth.
- CROWNS — 1 per tooth per consecutive 60 months; covered only when a filling cannot restore the tooth.
- POST AND CORES — Covered only for teeth that have had root canal therapy.
- SCALING AND ROOT PLANING — 1 per quadrant per consecutive 24 months.
- ROOT CANAL THERAPY — 1 per tooth per lifetime.
- PERIODONTAL MAINTENANCE — 2 times per consecutive 12 months following active periodontal therapy.
- FULL DENTURES — 1 per consecutive 60 months; no allowance for precision attachments.
- PARTIAL DENTURES — 1 per consecutive 60 months; no allowance for precision attachments.
- RELINING/REBASING DENTURES — Permitted more than 6 months after initial insertion; 1 per 12 months.
- OSSEOUS GRAFTS — 1 per quadrant or site per consecutive 36 months.
- PERIODONTAL SURGERY — 1 per quadrant or site per consecutive 36 months per surgical area.
- OCCLUSAL GUARDS — 1 per 36 months; covered only if prescribed to control habitual grinding.
- FULL MOUTH DEBRIDEMENT — 1 time per consecutive 36 months.
- GENERAL ANESTHESIA — Covered only when clinically necessary.

GENERAL EXCLUSIONS

- Dental services that are not Necessary.
- Hospitalization or other facility charges.
- Any dental procedure performed solely for cosmetic or aesthetic reasons.
- Reconstructive surgery, regardless of whether incidental to a dental disease, injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning.
- Any dental procedure not directly associated with dental disease.
- Any dental procedure not performed in a dental setting.
- Procedures that are Experimental, Investigational, or Unproven, including regimens not accepted by the ADA Council on Dental Therapeutics.
- Placement of dental implants, implant-supported abutments, and prostheses.
- Drugs or medications obtainable with or without a prescription, unless dispensed and utilized in the dental office during the patient visit.
- Setting of facial bony fractures and treatment associated with the dislocation of facial skeletal hard tissue.
- Treatment of benign neoplasms, cysts, or other pathology involving benign lesions (except excisional removal).
- Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Orthognathic surgery and jaw alignment are not covered.
- Charges for failure to keep a scheduled appointment without 24 hours notice.
- Expenses for dental procedures begun prior to the covered person becoming enrolled.
- Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
- Attachments to conventional removable prostheses or fixed bridgework, including semi- or precision attachments.
- Procedures related to reconstruction of a patient's correct vertical dimension of occlusion (VDO).
- Replacement of crowns, bridges, and fixed or removable prosthetic appliances inserted prior to coverage, unless covered continuously for 12 months.
- Replacement of missing natural teeth lost prior to the onset of coverage until covered continuously for 12 months.
- Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
- Placement of fixed partial dentures solely for periodontal stability.
- Services rendered by a provider with the same legal residence as, or family member of, a covered person.
- Dental services rendered after the date individual coverage terminates.
- Acupuncture, acupressure, and other forms of alternative treatment, whether or not used as anesthesia.
- Replacement of retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment.
- Foreign services (unless required as an Emergency).
- Services received as a result of war or any act of war, declared or undeclared.
- Services for injuries or conditions covered by Workers' Compensation or employer liability laws.

DEMONSTRATION NOTICE

This Plan Summary is provided **solely for demonstration and sales-training purposes**. It is not an offer of coverage, not a binding document, and not an official publication of any insurance carrier. Rates shown are fictitious illustrative examples and do not represent actual carrier pricing.

Notice: This Summary of Benefits is provided for informational purposes and is not an offer of coverage. For a complete listing of coverage, including exclusions and limitations, refer to the Certificate of Coverage. If differences exist between this summary and the Certificate of Coverage, the Certificate of Coverage will govern.

Dental Services are covered when Necessary, provided by or under the direction of a Dentist, the least costly clinically-accepted treatment, and not otherwise excluded. Orthodontic benefits are subject to the Lifetime Maximum shown above. Replacement of crowns, bridges, dentures, inlays, or onlays is limited to once per 60 months. Root Canal Therapy is limited to 1 time per tooth per lifetime.

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