Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Insurer Name: Principal Life Insurance Company **Plan Name: THE AZOFF COMPANY LLC ALL MEMBERS**

Policy Type: PPO **Insurer Phone #:** 1-800-843-1371

Effective Date: Beginning on or after **07/01/2025** **Insurer Website:** www.principal.com

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND WHAT YOU WILL PAY FOR COVERED SERVICES. THIS IS A SUMMARY ONLY AND DOES NOT INCLUDE THE PREMIUM COSTS OF THIS DENTAL BENEFITS PACKAGE. PLEASE CONSULT YOUR EVIDENCE OF COVERAGE AND DENTAL CONTRACT FOR DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. FOR MORE INFORMATION ABOUT YOUR COVERAGE, VISIT THE INSURER WEBSITE AT WWW.PRINCIPAL.COM OR CALL 1-800-843-1371.

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	In-Network	Out-of-Network
Dental	Preventive & Diagnostic None 3 times the per individual amount Basic $50 per individual 3 times the per individual amount Major $50 per individual 3 times the per individual amount	Preventive & Diagnostic None 3 times the per individual amount Basic $50 per individual 3 times the per individual amount Major $50 per individual 3 times the per individual amount
Orthodontia	$0	$0

- **The deductible applies to all services as noted above.**
- A **deductible** is the amount you are required to pay for covered dental services each policy year before the insurer begins to pay for the cost of covered dental treatment.
- **In-network services** are dental care services provided by dentists or other licensed dental care providers that contract with your insurer for alternative rates of payment for dental services.
- **Out-of-network services** are dental care services provided by dentists or other licensed dental care providers that have not contracted with your insurer for alternative rates of payment.

Part III: MAXIMUMS POLICY WILL PAY

Maximum	In-Network	Out-of-Network
Annual Maximum	$2,500	$2,500
Lifetime or Annual Maximum for Orthodontia	$1,500 per individual per lifetime	$1,500 per individual per lifetime

- **Annual maximum** is the maximum dollar amount your policy will pay towards the cost of dental care within a specific period of time, usually a consecutive 12-month or calendar year period. Not all services accrue to the annual maximum.
- **Lifetime maximum** means the maximum dollar amount your policy providing dental benefits will pay for the life of the enrollee. Lifetime maximums usually apply to specific services, such as orthodontic treatment.

Part IV: WAITING PERIODS

Waiting Periods: No waiting period.

Part V: WHAT YOU WILL PAY

All copayments and coinsurance costs shown in this chart apply after your deductible has been met, if a deductible applies. The Common Dental Procedures fit into one of the following applicable categories: Preventive & Diagnostic, Basic or Major. The Benefit Limitations and Exclusions column includes common limitations and exclusions only. For a full list, see the full disclosure document referenced in the Benefit Limitations and Exclusions column.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions[1]
Oral Exam	Preventive & Diagnostic	0%	0%	1 per 6 months
Bitewing X-ray	Preventive & Diagnostic	0%	0%	Only one set will be covered in any year
Cleaning	Preventive & Diagnostic	0%	0%	1 per 6 months
Filling	Basic	0%	20%	Amalgam or resin-based (composite)

Extraction, Erupted Tooth or Exposed Root	Basic	0%	20%	There will be no separate benefit payable for bone grafting of an extraction site.
Root Canal	Basic	0%	20%	Complex endodontics (root canal therapy for molar teeth)
Scaling and Root Planing	Basic	0%	20%	Covered once each quadrant every 24 months.
Ceramic Crown	Major	40%	50%	1 per 120 months if tooth cannot be restored by a filling
Removable Partial Denture	Major	40%	50%	1 per 120 months
Extraction, Erupted Tooth with Bone Removal	Basic	0%	20%	There will be no separate benefit payable for bone grafting of an extraction site.
Orthodontia	Orthodontia	50%	50%	Adult/Child

[1]Refer to the Description of Benefits, Schedule of Dental Procedures in the certificate for a full list of limitations and exclusions.

Part VI: COVERAGE EXAMPLES

THESE EXAMPLES DO NOT REPRESENT A COST ESTIMATOR OR GUARANTEE OF PAYMENT. The examples provided represent commonly used services in the categories of Diagnostic and Preventive, Basic, and Major Services for illustrative purposes and to compare this policy to other dental policies you may be considering. Your actual costs will likely be different from those shown in the chart below depending on the actual care you receive, the prices your providers charge and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and the summary of excluded services under the plan.

Dana Has a Dental Appointment with a New Dentist	Sam Needs a Tooth Filled	Maria Needs a Crown

New patient exam, x-rays (FMX) and cleaning		Resin-based composite - one surface, posterior		Crown - porcelain/ceramic substrate	
Dana's Visit	**Dana's Cost**	**Sam's Visit**	**Sam's Cost**	**Maria's Visit**	**Maria's Cost**
Total Cost of Care	In-network: $400.00 Out-of-network: $550.00	Total Cost of Care	In-network: $150.00 Out-of-network: $200.00	Total Cost of Care	In-network: $1,300.00 Out-of-network: $1,750.00
Deductible	In-network: $0.00 Out-of-network: $0.00	Deductible	In-network: $50.00 Out-of-network: $50.00	Deductible	In-network: $50.00 Out-of-network: $50.00
Annual Maximum (Plan will pay)	In-network: $2,500.00 Out-of-network: $2,500.00	Annual Maximum (Plan will pay)	In-network: $2,500.00 Out-of-network: $2,500.00	Annual Maximum (Plan will pay)	In-network: $2,500.00 Out-of-network: $2,500.00
Patient Cost (coinsurance)	In-network: $0.00 Out-of-network: $0.00	Patient Cost (coinsurance)	In-network: $0.00 Out-of-network: $30.00	Patient Cost (coinsurance)	In-network: $253.60 Out-of-network: $680.50
In this example, Dana would pay (includes coinsurance and deductible, if applicable):	In-network: $0.00 Out-of-network: $83.00	**In this example, Sam would pay (includes coinsurance and deductible, if applicable):**	In-network: $111.00 Out-of-network: $80.00	**In this example, Maria would pay (includes coinsurance and deductible, if applicable):**	In-network: $919.60 Out-of-network: $1,119.50

Summary of what is not covered or subject to a limitation	1 per 6 months Out-of-network: amount over usual and customary	Summary of what is not covered or subject to a limitation	In-network: Based on amalgam filling Out-of-network: Based on amalgam filling and amount over usual and customary	Summary of what is not covered or subject to a limitation	In-network: 1 per 120 months if tooth cannot be restored by a filling Based on prcelain fused to noble metal Out-of-network: Based on porcelain fused to noble metal and amount over usual and customary