

---

# Your dental benefits



Scan for information  
about dental insurance.

## Policyholder: SELECT PRODUCTS HOLDINGS LLC

### Group voluntary dental insurance

#### Benefit summary for all members

Your coverage renews every February 1

This summary was created on 12/27/2024 and shows benefits available at that time.

#### 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 |
|                              | In-network                                                                                                                                                                                                                                                                                                                                                                                                                               | Out-of-network           | In-network | Out-of-network               |
| Preventive                   | \$0                                                                                                                                                                                                                                                                                                                                                                                                                                      | \$0                      | 100%       | 100%                         |
| Basic                        | \$50                                                                                                                                                                                                                                                                                                                                                                                                                                     | \$50                     | 80%        | 80%                          |
| Major                        | \$50                                                                                                                                                                                                                                                                                                                                                                                                                                     | \$50                     | 50%        | 50%                          |
| Orthodontia                  | \$0                                                                                                                                                                                                                                                                                                                                                                                                                                      | \$0                      | 50%        | 50%                          |
| Additional provisions        |                                                                                                                                                                                                                                                                                                                                                                                                                                          |                          |            |                              |
| Family deductible            | 2 times the per person deductible amount                                                                                                                                                                                                                                                                                                                                                                                                 |                          |            |                              |
| Combined deductible          | Your in-network deductibles for basic and major services are combined.<br>Your out-of-network deductibles for basic and major are combined.<br>Your services applied to the in-network deductible will apply to the out-of-network deductible and vice versa.                                                                                                                                                                            |                          |            |                              |
| Combined maximum             | Your calendar year maximum for preventive, basic, and major in-network services are combined.<br>Your calendar year maximum for preventive, basic, and major out-of-network services are combined. In-network calendar year maximums are \$1,500 per person or out-of-network calendar year maximums are \$1,500 per person.<br>Your services applied to the in-network maximum will apply to the out-of-network maximum and vice versa. |                          |            |                              |
| Orthodontia lifetime maximum | \$1,000 PPO in-network maximum / \$1,000 PPO out-of-network maximum                                                                                                                                                                                                                                                                                                                                                                      |                          |            |                              |
| Maximum accumulation         | Included                                                                                                                                                                                                                                                                                                                                                                                                                                 |                          |            |                              |
| Plan type                    | Unscheduled                                                                                                                                                                                                                                                                                                                                                                                                                              |                          |            |                              |

Insurance issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392

## Who can buy coverage?

- You may buy coverage if you're an active, full-time employee. 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.

## Which procedures are covered, and how often?

### Preventive

|                   |                                                                                 |
|-------------------|---------------------------------------------------------------------------------|
| Routine exams     | Once per six months                                                             |
| Routine cleanings | Once per six months                                                             |
| 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)       |
| Sealants          | Covered only for dependent children under age 14; once per tooth each 36 months |

### Basic

|                                                               |                                                                                                                      |
|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|
| 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                                                                                 |
| Oral surgery                                                  | Simple and complex                                                                                                   |
| 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                                                                                      |
| Harmful habit appliance                                       | Covered only for dependent children under age 14                                                                     |

Insurance issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392

| Major        |                                                                                                                                    |
|--------------|------------------------------------------------------------------------------------------------------------------------------------|
| Crowns       | Each 120 months per tooth if tooth cannot be restored by a filling                                                                 |
| Core buildup | Each 120 months per tooth                                                                                                          |
| Implants     | Each 120 months per tooth                                                                                                          |
| Bridges      | 120 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 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |

## 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?

- 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

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) Ortho treatment was started and bands or appliances were inserted while insured under any prior group coverage, and
- 2) Ortho treatment has been continued while insured under this policy.

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.

---

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.

© 2024 Principal Financial Services, Inc., Principal, Principal and symbol design and Principal Financial Group are trademarks and service marks of Principal Financial Services, Inc., a member of the Principal Financial Group.

Insurance issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392

# SELECT PRODUCTS HOLDINGS LLC

## Dental

Estimated employee monthly premium amounts

End of rate guarantee period: 01/31/2026

| Coverage                | Premium |
|-------------------------|---------|
| Employee only           | 30.28   |
| Employee and spouse     | 61.58   |
| Employee and child(ren) | 81.57   |
| Employee and family     | 119.01  |

Dental insurance from Principal® is issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392.

This summary is not a complete statement of the rights, benefits, limitations and exclusions of the coverage described here. For cost and coverage details, contact your Principal® representative.

Principal, Principal and symbol design and Principal Financial Group are trademarks and service marks of Principal Financial Services, Inc., a member of the Principal Financial Group.

