Policyholder: DONGALEN ENTERPRISES, INC DBA INTERSTATE ADVANCED MATERIALS

Group Dental Insurance Benefit summary

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 (non ca managers electing high dental plan)				
	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	3 times the per person deductible amount			
Combined deductible	Your in-network deductiblesfor basic and major services are combined. Your out-of-network deductibles for basic and major are combined. 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. 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. Your services applied to the in-network maximum will apply to the out-of-network maximum and vice versa.			
Orthodontia lifetime maximum	$1,500 PPO in-network maximum / $1,500 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.
  - 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?

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	Twice 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; twice per calendar year
Fillings	Replacement fillings every 24 months
Composite (tooth colored)	Covered on posterior teeth
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
Occlusal guards (night guards)	One guard per 36 months

Major	
Crowns	Each 60 months per tooth if tooth cannot be restored by a filling. Porcelain facing covered on molars
Core buildup	Each 60 months per tooth
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 99th 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 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.

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.

BOOKLET-CERTIFICATE NOTICE
CONFIDENTIAL COMMUNICATIONS REQUEST

The state of California wants you to know you have the right to make a request to receive communications of confidential health care information from us by alternative means or at an alternative location.

To make this request, you must complete, sign, and submit a "Confidential Communications Request" form. This form, along with directions on how to complete and return it to us, can be found on our website at: https://www.principal.com/help/help-individuals/find-form under "Restrict access to Private Health Information".

If you need assistance locating the request form, you may contact us at 1-800-843-1371.

This notice is for your information only and does not become a part or condition of this booklet-certificate.

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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) The lifetime maximum under any prior group coverage has not been exceeded, 2) Ortho treatment was started and bands or appliances were inserted while insured under any prior group coverage, and 3) Ortho treatment has been continued while insured under this policy. Principal Life will credit payments made by the prior carrier toward the Principal Life lifetime ortho payment limit. 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.

Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Insurer Name: Principal Life Insurance Company

Plan Name: DONGALEN ENTERPRISES, INC DBA INTERSTATE ADVANCED MATERIALS NON CA MANAGERS ELECTING HIGH DENTAL PLAN

Policy Type: PPO

Insurer Phone #: 1-800-843-1371

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	$1,500	$1,500
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%	2 per year

Bitewing X-ray	Preventive & Diagnostic	0%	0%	Only one set will be covered in any year
Cleaning	Preventive & Diagnostic	0%	0%	2 per year
Filling	Basic	20%	20%	Amalgam or resin-based (composite)
Extraction, Erupted Tooth or Exposed Root	Basic	20%	20%	There will be no separate benefit payable for bone grafting of an extraction site.
Root Canal	Basic	20%	20%	Complex endodontics (root canal therapy for molar teeth)
Scaling and Root Planing	Basic	20%	20%	Covered once each quadrant every 24 months.
Ceramic Crown	Major	50%	50%	1 per 60 months if tooth cannot be restored by a filling
Removable Partial Denture	Major	50%	50%	1 per 60 months
Extraction, Erupted Tooth with Bone Removal	Basic	20%	20%	There will be no separate benefit payable for bone grafting of an extraction site.
Orthodontia	Orthodontia	50%	50%	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: $1,500.00 Out-of-network: $1,500.00	Annual Maximum (Plan will pay)	In-network: $1,500.00 Out-of-network: $1,500.00	Annual Maximum (Plan will pay)	In-network: $1,500.00 Out-of-network: $1,500.00
Patient Cost (coinsurance)	In-network: $0.00 Out-of-network: $0.00	Patient Cost (coinsurance)	In-network: $7.80 Out-of-network: $30.00	Patient Cost (coinsurance)	In-network: $317.00 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: $118.80 Out-of-network: $80.00	**In this example, Maria would pay (includes coinsurance and deductible, if applicable):**	In-network: $983.00 Out-of-network: $1,119.50
Summary of what is not covered or subject to a limitation	2 per year 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 60 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