



Policyholder: BOUTIQUE AIR

Group dental insurance for ca mbrs elec low plan

Effective date: 01/01/2024

The State of California (CA) Department of Insurance is requiring all insurance carriers to provide the CA language assistance notice, non-discrimination notice and a summary of dental benefits and coverage disclosure matrix.

Attached are four separate documents for your employees:

- 1) Principal Life Insurance Company's dental benefit summary provides a brief outline of dental benefits.
- 2) California language assistance notice
- 3) California non-discrimination notice
- 4) California summary of dental benefits and coverage disclosure matrix required by the state.
 - a) The group policyholder is required to provide this document to employees at:
 - i) initial enrollment.
 - ii) open enrollment.
 - iii) renewal, and
 - iv) if there are amendments to the dental benefits.

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Policyholder: BOUTIQUE AIR

Group dental insurance

Benefit summary for ca mbrs elec low plan

Your coverage renews every January 1

This summary was created on 11/07/2023 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		
	EPO	In-network	Out-of-network	EPO	In-network	Out-of-network
Preventive	\$0	\$0	\$0	100%	100%	100%
Basic	\$50	\$50	\$50	80%	80%	80%
Major	\$50	\$50	\$50	50%	50%	50%
Additional provisions						
Family deductible	3 times the person deductible amount.					
Combined deductible	Your deductibles that are in and out-of-network for basic and major services are combined.					
Combined maximums	Maximums for preventive, basic, and major procedures are combined for EPO, PPO in- and out-of-network. Calendar year EPO maximums are \$1,000 per person, calendar year PPO in-network maximums are \$1,000 per person, or calendar year PPO out-of-network maximums are \$1,000 per person.					
Maximum accumulation	Included					
Plan type	Scheduled					

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.
- If you're covered, you may buy coverage for your dependents, if they're not confined at home, in a hospital or skilled nursing facility (this is referred to as Period of Limited Activity)

Additional eligibility requirements may apply.

Which procedures are covered, and how often?

Preventive	
Routine exams	Two per calendar year
Routine cleanings	Twice per calendar year
Bitewing X-rays	Once per calendar year
Full mouth X-rays	Once every 36 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
Basic	
Periodontal maintenance	If three months have passed since active surgical periodontal treatment; subject to Routine cleaning frequency limit
Fillings	Replacement fillings every 24 months
Composite (tooth colored) fillings	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	One guard per 36 months
Harmful habit appliance	Covered only for dependent children under age 16

Major	
Crowns	Each 60 months per tooth if tooth cannot be restored by a filling
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

Additional benefits

Scheduled / MAC design	In- and out-of-network claim payments are based on the amounts agreed to by network dentists, known as a negotiated fee schedule. If the submitted charge is more than the scheduled amount you may be responsible for paying the difference for out of network claims.
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?

- Missing tooth provision –This means the initial placement of bridges, partials, dentures, and implant services to replace teeth missing before this coverage starts may not be covered. If the policy your employer purchased replaces coverage with another carrier, continuous coverage under the prior plan may be applied and you may be eligible for coverage to replace teeth missing before this coverage started. Missing tooth provision doesn't apply to pediatric essential benefits.
- 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.

GH 198 CCR CA



[principal.com](https://www.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.

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

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. Written translations are available in Spanish only. For help, call us at the number listed on your ID card or 1-800-247-4695. For more help call the CA Dept. of Insurance at 1-800-927-4357.

Servicios de idiomas sin costo. Solicite un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-800-247-4695. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-800-247-4695. للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357. Arabic.

Անվճար Լեզվական ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-800-247-4695 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆոռնիայի Ապահովագրության Բաժանմունք: Armenian

免費語言服務。 您可獲得口譯員服務，用中文把文件唸給您聽。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打 1-800-247-4695 與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 與加州保險部聯絡。 Chinese

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-800-247-4695 . Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

मुफ्त भाषा सेवा. आपको दुभाषिया की सेवा मिल सकती है. दुभाषिए आपको दस्तावेज़ पढ़वा कर सुना सकते हैं और कुछ आपको आपकी भाषा में दस्तावेज़ भेज देते हैं. लिखित अनुवाद सिर्फ स्पेनिश में उपलब्ध हैं. सहायता के लिए, अपने आई कार्ड पर दिए गए नंबर या 1-800-247-4695 पर कॉल करें. अधिक सहायता के लिए, 1-800-927-4357 पर CA डिपार्टमेंट ऑफ़ इश्योरेंस से बात करें. Hindi

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または 1-800-247-4695 までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。 Japanese



Discrimination is against the law. Principal Life Insurance Company (Principal Life) follows State and Federal civil rights laws. Principal Life does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation in connection with the group dental and vision care insurance benefits provided to customers.

No Cost Language Services

Principal Life provides access to no cost language services for people whose primary language is not English. You can get an interpreter. You can get documents read to you and some sent to you in your language. Written translations are available in Spanish only.

Relay Services for the hearing impaired

Principal Life is approved to assist customers using any Federal Communications Commission (FCC) approved relay service provider. Relay services include Video Relay Service (VRS) which allows the hearing impaired to place and receive calls with a professional American Sign Language (ASL) interpreter via a videophone and a high-speed internet connection. VRS and videophone calls are free to the hearing impaired.

A list of FCC approved relay service providers can be accessed at: <https://www.fcc.gov/general/internet-based-trs-providers>.

If you need these services, contact Principal Life between 7:30 am and 6:00 pm (CST) by calling the number on your ID card or 1-800-247-4695.

HOW TO FILE A GRIEVANCE

If you believe that Principal Life has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance with Principal Life's Office of the General Counsel. You can file a grievance by phone, in writing, or electronically at:

**Principal Life Insurance Company
Office of the General Counsel
711 High Street
Des Moines, IA 50392-0300
Phone: 515-247-6498
E-mail: CSDClaims@exchange.principal.com**

CALIFORNIA DEPARTMENT OF INSURANCE

You can also file a civil rights complaint with the California Department of Insurance by phone, in writing, or electronically:

- By phone: Call **1-800-927-4357**. If you cannot speak or hear well, please call **TDD 1-800-482-4833**.
- In writing: Fill out a complaint form or send a letter to:
California Department of Insurance
Consumer Services and Market Conduct Branch
Consumer Services Division
300 South Spring Street, South Tower
Los Angeles, CA 90013

Complaint forms are available at:
<http://www.insurance.ca.gov/01-consumers/101-help/>

Electronically: Visit the Getting Help page at <http://www.insurance.ca.gov/01-consumers/101-help/>

OFFICE OF CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.
- In writing: Fill out a complaint form or send a letter to:
U.S. Department of Health and Human Services 200
Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

- Electronically: Visit the Office for Civil Rights Complaint Portal at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Insurer Name: Principal Life Insurance Company **Plan Name:** BOUTIQUE AIR
CA MBRS ELEC LOW PLAN

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

Effective Date: Beginning on or after 01/01/2024 **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 EPO: None 3 times the per individual amount PPO: None 3 times the per individual amount Basic EPO: \$50 per individual 3 times the per individual amount PPO: \$50 per individual 3 times the per individual amount Major EPO: \$50 per individual 3 times the per individual amount PPO: \$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	Not covered	Not covered
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- **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	EPO: \$1,000 per individual PPO: \$1,000 per individual	\$1,000 per individual

- **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
<i>Oral Exam</i>	Preventive & Diagnostic	EPO: 0% PPO: 0%	0%	2 per year

<i>Bitewing X-ray</i>	Preventive & Diagnostic	EPO: 0% PPO: 0%	0%	Only one set will be covered in any year
<i>Cleaning</i>	Preventive & Diagnostic	EPO: 0% PPO: 0%	0%	2 per year
<i>Filling</i>	Basic	EPO: 20% PPO: 20%	20%	Amalgam or resin-based (composite)
<i>Extraction, Erupted Tooth or Exposed Root</i>	Basic	EPO: 20% PPO: 20%	20%	There will be no separate benefit payable for bone grafting of an extraction site.
<i>Root Canal</i>	Basic	EPO: 20% PPO: 20%	20%	Complex endodontics (root canal therapy for molar teeth)
<i>Scaling and Root Planing</i>	Basic	EPO: 20% PPO: 20%	20%	Covered once each quadrant every 24 months.
<i>Ceramic Crown</i>	Major	EPO: 50% PPO: 50%	50%	1 per 60 months if tooth cannot be restored by a filling
<i>Removable Partial Denture</i>	Major	EPO: 50% PPO: 50%	50%	1 per 60 months. Initial placement of complete or partial dentures to replace teeth which were missing prior to the effective date of the insured person's coverage will not be covered unless it includes the replacement of a Functioning Natural Tooth extracted while insured.

<i>Extraction, Erupted Tooth with Bone Removal</i>	Basic	EPO: 20% PPO: 20%	20%	There will be no separate benefit payable for bone grafting of an extraction site.
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¹Refer 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: EPO: \$400.00 PPO: \$400.00 Out-of-network: \$550.00	Total Cost of Care	In-network: EPO: \$150.00 PPO: \$150.00 Out-of-network: \$200.00	Total Cost of Care	In-network: EPO: \$1,300.00 PPO: \$1,300.00 Out-of-network: \$1,7500.00
Deductible	In-network: EPO: \$0.00 PPO: \$0.00 Out-of-network: \$0.00	Deductible	In-network: EPO: \$50.00 PPO: \$50.00 Out-of-network: \$50.00	Deductible	In-network: EPO: \$50.00 PPO: \$50.00 Out-of-network: \$50.00

Annual Maximum (Plan will pay)	In-network: EPO: \$1,000.00 PPO: \$1,000.00 Out-of-network: \$1,000.00	Annual Maximum (Plan will pay)	In-network: EPO: \$1,000.00 PPO: \$1,000.00 Out-of-network: \$1,000.00	Annual Maximum (Plan will pay)	In-network: EPO: \$1,000.00 PPO: \$1,000.00 Out-of-network: \$1,000.00
Patient Cost (coinsurance)	In-network: EPO: \$0.00 PPO: \$0.00 Out-of-network: \$0.00	Patient Cost (coinsurance)	In-network: EPO: \$7.80 PPO: \$7.80 Out-of-network: \$30.00	Patient Cost (coinsurance)	In-network: EPO: \$317.00 PPO: \$317.00 Out-of-network: \$680.50
In this example, Dana would pay (includes coinsurance and deductible, if applicable):	In-network: EPO: \$0.00 PPO: \$0.00 Out-of-network: \$83.00	In this example, Sam would pay (includes coinsurance and deductible, if applicable):	In-network: EPO: \$118.80 PPO: \$118.80 Out-of-network: \$80.00	In this example, Maria would pay (includes coinsurance and deductible, if applicable):	In-network: EPO: \$983.00 PPO: \$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 porcelain fused to noble metal Out-of-network: Based on porcelain fused to noble metal and amount over usual and customary

