



Policyholder: AURORA UNIVERSITY

# Voluntary Dental PPO Benefit Summary

Effective Date: 01/01/2010

This chart provides you a brief summary of the key benefits of the dental insurance available from Principal Life Insurance Company. Following the chart, you will find additional information to answer questions you may have. For a complete list of all your dental insurance benefits and restrictions, please refer to your booklet or contact your plan administrator.

Eligibility	
<b>Benefit Choice</b>	Eligible members may select ONE OF THE TWO BENEFIT OPTIONS outlined below

## Option 1

Benefits Payable				
<b>Job Class</b>	Members Electing Network Access Plan			
<b>Network</b>	Dental Preferred Provider Organization (PPO)			
<b>Network Service Area</b>	Includes the Illinois counties of Cook, DuPage, Kane, Lake, McHenry, Will, DeKalb, Kankakee, Kendall, Winnebago, Champaign, Coles, Effingham, Ford, Fulton, Jackson, Logan, Macoupin, McDonough, McLean, Morgan, Peoria, Sangamon, Union, Vermillion, Wayne, Whiteside, Woodford.			
	Calendar Year Deductible		Coinsurance (Policy Pays)	
	In-Network	Non-Network	In-Network	Non-Network
<b>Unit 1 – Preventive</b>	\$0	\$0	100%	100%
<b>Unit 2 – Basic</b>	\$50	\$50	80%	80%
<b>Unit 3 – Major</b>	\$50	\$50	50%	50%
<b>Family Deductible Maximum</b>	3 times the per person deductible amount			
<b>Combined Deductible</b>	In-network deductibles for basic and major procedures are combined. Non-network deductibles for basic and major procedures are combined.			
<b>Combined Maximums</b>	Maximums for preventive, basic, and major procedures are combined. In-network Calendar year maximums are \$1,000 per person. Non-network Calendar year maximums are \$1,000 per person.			
<b>Maximum Accumulation</b>	This allows for a portion of unused maximum benefit to carry over to next year's maximum benefit amount. 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 maximum benefit or \$1000. If qualification is met, 50% of the threshold is carried over to next year's maximum benefit. You can accumulate no more than four times the carry over amount.			

**How Are Dental Procedures Covered Under Option 1?**

The list of common procedures shows what unit the procedure is included in and how often they are covered.

<p><b>Unit 1 – Preventive Procedures</b></p>	<ul style="list-style-type: none"> <li>• Routine exams - two per 12 months</li> <li>• Routine cleaning (prophylaxis) - two per 12 months (Expectant mothers, diabetics and those with heart disease receive one additional routine or periodontal cleaning within a 12 month period.)</li> <li>• Emergency exams – subject to Routine exam frequency limit</li> <li>• Second Opinion Consultation</li> <li>• Fluoride – one treatment[s] each 12 months (covered only for dependent children under age 16)</li> <li>• Sealants – on first and second permanent molars for dependent children under age 16; one each tooth each 36 months</li> <li>• X-rays - Bitewing (one set[s] every 12 months), occlusal, periapical</li> <li>• X-rays – Full mouth survey (one every 60 months), extraoral</li> </ul>
<p><b>Unit 2 – Basic Procedures</b></p>	<ul style="list-style-type: none"> <li>• Periodontal prophylaxis - if three months have elapsed after active surgical periodontal treatment; subject to Routine cleaning frequency limit (Expectant mothers, diabetics and those with heart disease receive one additional routine or periodontal cleaning within a 12 month period.)</li> <li>• Space maintainers - covered only for dependent children under age 16; repairs not covered</li> <li>• Harmful Habit Appliance - covered only for dependent children under age 16</li> <li>• Fillings and stainless steel crowns</li> <li>• Composite fillings on molars</li> <li>• General Anesthesia/IV Sedation</li> <li>• Non-surgical Periodontics, including scaling and root planing - once each quadrant each 24 months (For expectant mothers, diabetics and those with heart disease, this procedure is provided with no deductible and 100% coinsurance.)</li> <li>• Periodontal Surgical Procedures – one each quadrant each 36 months</li> <li>• Repairs to Partial Denture, Bridge, Crown, Relines, Rebasings, Tissue Conditioning and Adjustment to Bridge/Denture, within policy limitations</li> </ul>
<p><b>Unit 3 – Major Procedures</b></p>	<ul style="list-style-type: none"> <li>• Simple Oral Surgery</li> <li>• Complex Oral Surgical Procedures</li> <li>• Simple Endodontics (root canal therapy for anterior teeth)</li> <li>• Complex Endodontics (root canal therapy for molar teeth)</li> <li>• Crowns – each 120 months per tooth if tooth cannot be restored by a filling.</li> <li>• Inlays, Onlays, Cast Post and Core, Core Buildup - each 120 months per tooth</li> <li>• Bridges - Initial placement / Replacement of bridges 120 months old.</li> <li>• Dentures - Initial placement of complete or partial dentures / Replacement of complete or partial dentures over 60 months old</li> </ul>

There is Coordination of Benefits, which is a procedure for limiting benefits from two or more carriers to 100% of the claimant's covered expenses.

VOLUNTARY DENTAL

Option 2

Benefits Payable				
<b>Job Class</b>	Members Electing Split Value Plan			
<b>Network</b>	Dental Preferred Provider Organization (PPO)			
<b>Network Service Area</b>	Includes the Illinois counties of Cook, DuPage, Kane, Lake, McHenry, Will, DeKalb, Kankakee, Kendall, Winnebago, Champaign, Coles, Effingham, Ford, Fulton, Jackson, Logan, Macoupin, McDonough, McLean, Morgan, Peoria, Sangamon, Union, Vermillion, Wayne, Whiteside, Woodford.			
	Calendar Year Deductible		Coinsurance (Policy Pays)	
	In-Network	Non-Network	In-Network	Non-Network
<b>Unit 1 – Preventive</b>	\$0	\$0	100%	80%
<b>Unit 2 – Basic</b>	\$0	\$0	80%	70%
<b>Unit 3 – Major</b>	\$0	\$0	50%	40%
<b>Combined Maximums</b>	Maximums for preventive, basic, and major procedures are combined. In-network Calendar year maximums are \$1,000 per person. Non-network Calendar year maximums are \$1,000 per person.			
<b>Maximum Accumulation</b>	This allows for a portion of unused maximum benefit to carry over to next year's maximum benefit amount. To qualify, you must have had a dental service performed within the Calendar year year and used less than the maximum threshold. The threshold is equal to the lesser of 50% of the maximum benefit or \$1000. If qualification is met, 50% of the threshold is carried over to next year's maximum benefit. You can accumulate no more than four times the carry over amount.			

**How Are Dental Procedures Covered Under Option 2?**

The list of common procedures shows what unit the procedure is included in and how often they are covered.

<p><b>Unit 1 – Preventive Procedures</b></p>	<ul style="list-style-type: none"> <li>• Routine exams - two per 12 months</li> <li>• Routine cleaning (prophylaxis) - two per 12 months (Expectant mothers, diabetics and those with heart disease receive one additional routine or periodontal cleaning within a 12 month period.)</li> <li>• Emergency exams – subject to Routine exam frequency limit</li> <li>• Second Opinion Consultation</li> <li>• Fluoride – one treatment[s] each 12 months (covered only for dependent children under age 16)</li> <li>• Sealants – on first and second permanent molars for dependent children under age 16; one each tooth each 36 months</li> <li>• X-rays - Bitewing (one set[s] every 12 months), occlusal, periapical</li> <li>• X-rays – Full mouth survey (one every 60 months), extraoral</li> </ul>
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<p><b>Unit 3 – Major Procedures</b></p>	<ul style="list-style-type: none"> <li>• Simple Oral Surgery</li> <li>• Complex Oral Surgical Procedures</li> <li>• Simple Endodontics (root canal therapy for anterior teeth)</li> <li>• Complex Endodontics (root canal therapy for molar teeth)</li> <li>• Crowns – each 120 months per tooth if tooth cannot be restored by a filling.</li> <li>• Inlays, Onlays, Cast Post and Core, Core Buildup- each 120 per tooth</li> <li>• Bridges - Initial placement / Replacement of bridges 120 months old.</li> <li>• Dentures - Initial placement of complete or partial dentures / Replacement of complete or partial dentures over 60 months old</li> </ul>

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## Understanding Your Dental Benefits

### Am I Eligible For Coverage?

To be eligible for coverage, you must qualify as an eligible member and be considered actively at work.

You must be enrolled for dental coverage before it can be offered to your dependents. Eligible dependents include your spouse and unmarried minor children. Additional eligibility requirements may apply.

### How Do I Find A Participating Provider?

Use the Provider Directory on [www.principal.com](http://www.principal.com) to locate nearby dentists or see if your dentist participates in your network.

1	Visit <a href="http://www.principal.com">www.principal.com</a> .
2	Under the <b>Quick Links</b> heading on the left-hand side, click <b>Provider Directory</b> .
3	In the left-hand navigation under <b>Providers/Networks</b> , click <b>Search For A Dental Provider</b> .
4	Begin your search by picking the <b>state</b> where you would like to find a provider. Next, specify a <b>network</b> . Depending on the network chosen, you may be transferred to a partner site.
5	Enter the <b>name of the provider</b> you are looking for (if known). If you are looking for a nearby dentist, enter the <b>city and state and/or ZIP code</b> . Be sure to indicate <b>how far you are willing to travel</b> .
6	Select the <b>desired specialty</b> or use the No Specialty Preference default. Click <b>Continue</b> .

You may nominate your dentist for inclusion in our network. Please submit the dentist's name, address, phone and specialty by calling 1-800-832-4450, or submit through [www.principal.com](http://www.principal.com).

**Is There Additional Network Information?**

<b>In-network Coverage</b>	The financial arrangement with the providers in this network is a fee-for-service arrangement. A fee schedule is included in the contract. When a provider signs the contract, he or she agrees to accept the fee schedule maximum allowance. In-network providers will not balance bill insureds for amounts over the agreed schedule.
<b>Network Provider Selection</b>	Providers must complete an initial application providing general information that includes, but is not limited to, history information about malpractice, mental health conditions, chemical substance abuse, felony convictions, and any ongoing physical impairment or conditions. Principal Life works with Dentistat and the Insurance Dentists of America (IDOA), the country's most experienced independent credentialing verification organization, to provide a quality managed dental care network. Before a provider can join The Principal Plan Dental network, IDOA screens the applicant's profile against previously established norms and standards. Only those providers who meet the requirements of both Principal Life and IDOA may join. The work doesn't stop when a provider becomes part of the network. IDOA continuously monitors practice patterns of approved contracted providers.
<b>Emergency Coverage</b>	If an insured requires emergency treatment and cannot reach an In-network provider, benefits will be paid as if the service was provided by an In-network provider.

**How Are Complaints Handled?**

A "complaint" is a written communication primarily expressing a grievance and is filed by a consumer, a healthcare provider, or your representative either directly with Principal Life Insurance Company or via the Illinois Insurance Department. Complaints may be handwritten or typed and may be transmitted electronically, by facsimile, or by U.S. Mail.

Regulator complaints are first recorded by the corporate complaint register and forwarded to Group Life and Health Compliance for assignment to a complaint handler. Non-regulator complaints are handled by the Group Life & Health compliance department, the local claim service center, or the administration or underwriting department assigned to the consumer's account.

Once a complaint is received, an acknowledgement letter is immediately sent identifying the name, address, and phone number of the person handling the complaint. An investigation is then made of the complaint. Within twenty-one (21) calendar days of the date of the Illinois Insurance Department's letter (or earlier, if specified by the Insurance Department), a substantive response is provided pursuant to instruction in the Illinois Insurance Department's cover letter. Within fifteen (15) working days from the receipt of a non-regulator complaint, a substantive response is provided to the complainant.

The response includes a description of how and when the consumer was covered with Principal Life, the policy provisions that govern the issues in question, what has transpired on the account, and an explanation of the decision either to uphold the original handling of the account or to take corrective action, why, and within what timing.

Principal Life maintains a complaint register that allows individual reconstruction of complaints as well as summary data.

## What Are The Restrictions Of My Coverage?

This Benefit Summary is a summary only. For a complete list of benefit restrictions, please refer to your booklet.

Limitations & Exclusions	
<b>Late Entrant Provision</b>	Those members enrolling more than 31 days after becoming eligible will be subject to an individual benefit waiting period, subject to policy guidelines.
<b>Missing Tooth</b>	Benefits for the initial placement of bridges, partials and dentures are not covered if those teeth were missing prior to becoming insured under the Principal Life policy. When the policy replaces coverage under a prior plan, continuous coverage under the prior plan may be applied to the missing tooth provision requirement.
<b>Prevailing Charge</b>	When using non-network providers, you pay any amount over the allowable charge.
<b>Other Limitations</b>	There are additional limitations to your coverage. A complete list is included in your booklet.



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Principal Life Insurance Company, Des Moines, Iowa 50392-0002, [www.principal.com](http://www.principal.com)

This benefit summary is for administrative purposes and is not a complete statement of benefits and restrictions. You'll receive a benefit booklet with details about your coverage. If there is a discrepancy between this summary and your benefit booklet, the benefit booklet prevails.

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