

Plan Year 7/1/2026 – 6/30/2027

|                                                                                                                        |                                       |                                                                                                                                                                             |
|------------------------------------------------------------------------------------------------------------------------|---------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>PLAN YEAR MAXIMUM BENEFIT</b>                                                                                       |                                       | \$2,000 per person – Services must be received by a PPO dentist.                                                                                                            |
| <b>ORTHODONTIC LIFETIME MAXIMUM</b><br>Children to age 19                                                              |                                       | \$2,000 per person – Treatment must be received by a PPO dentist. Orthodontia benefits already paid under either option will be applied under this plan's lifetime maximum. |
| <b>PLAN YEAR DEDUCTIBLE</b><br>Applies to Basic and Major Services                                                     |                                       | <b>Per Person Deductible:</b> \$25<br>There is no family deductible limit. Deductible will not be taken on services for children to age 13.                                 |
| <b>PPO MEMBER COST</b><br>Services are not covered outside the PPO network.                                            | <b>COVERED SERVICES</b>               | <b>BENEFIT INFORMATION</b><br>(Subject to Delta Dental guidelines)                                                                                                          |
| <b>PREVENTIVE AND DIAGNOSTIC SERVICES</b> - Preventive and Diagnostic services do not apply to Plan Year Maximum       |                                       |                                                                                                                                                                             |
| 0%                                                                                                                     | Oral Evaluation                       | Limited to 2 evaluations in a plan year.                                                                                                                                    |
|                                                                                                                        | Bitewing X-rays                       | Limited to 1 set in a plan year.                                                                                                                                            |
|                                                                                                                        | Full Mouth or Panoramic X-rays        | Limited to 1 in a 60-month period.                                                                                                                                          |
|                                                                                                                        | Routine Cleaning                      | Limited to 4 cleanings in a plan year.                                                                                                                                      |
|                                                                                                                        | Fluoride Treatments                   | Limited to 2 treatments in a plan year, for adults and children.                                                                                                            |
|                                                                                                                        | Space Maintainers                     | For premature loss of baby back teeth only under age 14.                                                                                                                    |
|                                                                                                                        | Sealants                              | 1 per tooth in 36 months under age 15 on unrestored permanent molars.                                                                                                       |
| <b>BASIC SERVICES</b> - Fillings, Endodontics (Root Canal), Periodontics (Gum Disease), and Oral Surgery (Extractions) |                                       |                                                                                                                                                                             |
| 30%                                                                                                                    | Amalgam, Resin and Composite Fillings | Benefit on the same surface limited to 1 in 12 months on posterior teeth.                                                                                                   |
|                                                                                                                        | Oral Surgery (Extractions)            |                                                                                                                                                                             |
|                                                                                                                        | General Anesthesia                    | Benefit with covered oral surgery only.                                                                                                                                     |
|                                                                                                                        | Surgical Periodontal (gums)           | Benefit once per quadrant every 36 months.                                                                                                                                  |
|                                                                                                                        | Root Canal Therapy                    | Benefit once per tooth.                                                                                                                                                     |
| <b>MAJOR SERVICES</b> - Crowns, Bridges, Partials, Dentures, Implants                                                  |                                       |                                                                                                                                                                             |
| 50%                                                                                                                    | Crowns                                | Benefit 1 per tooth in 60 months on same tooth. Not a benefit under age 12.                                                                                                 |
|                                                                                                                        | Dentures, Partials, Bridges           | Benefit 1 in 60 months. Not a benefit under age 16.                                                                                                                         |
|                                                                                                                        | Bridge/Denture Repair                 | Benefit after 6 months from insertion.                                                                                                                                      |
|                                                                                                                        | Denture Rebase/Reline                 | Benefit 6 months after initial insertion then benefit 1 in 36 months.                                                                                                       |
|                                                                                                                        | Implants                              | Benefit 1 per tooth in 60 months on the same tooth. Not covered under age 16.                                                                                               |
| <b>ORTHODONTICS</b> - Braces For Children to age 19 only                                                               |                                       |                                                                                                                                                                             |
| 50%                                                                                                                    | Complete orthodontic evaluation       |                                                                                                                                                                             |
|                                                                                                                        | Active orthodontic treatment          |                                                                                                                                                                             |

The PPO percentage of benefits is based on the PPO Schedule of Allowances.

**Right Start 4 Kids:** Covers children up to their 13th birthday at 100% with no deductible (for the same services outlined in the plan, up to the annual maximum, and subject to limitations and exclusions). The child must see a Delta Dental PPO or Premier provider to receive the 100% coinsurance. If an out-of-network provider is seen, the adult coinsurance levels will apply. Orthodontics is not covered at 100% but at the plan's listed coinsurance.

**Important Note:** This form provides only a brief description of services covered under your contract and does not list those services that are limited or excluded from coverage. Your employee benefit booklet provides a more complete explanation of your coverage, including limitations and exclusions. If differences exist between this summary of benefits and your employee benefit booklet, the benefit booklet will govern.