BMO

Delta Dental Plan Booklet

Low Plan

DELTA DENTAL®

Delta Dental of Illinois

2026 Plan Year

DELTA DENTAL®

Delta Dental of Illinois

Delta Dental PPO℠

Dental Benefits Booklet

BMO Bank N.A.

Low Plan

Group #20246

Effective Date: 01/01/26

DENTAL BENEFITS BOOKLET

This is a summary of your Group Dental Plan
prepared for Covered Individuals with:

BMO BANK N.A.

IMPORTANT: THIS BOOKLET IS NOT A SUMMARY PLAN DESCRIPTION (SPD). IT DOES NOT FULFILL THE REQUIREMENTS OF AN SPD AS REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA). IT IS INTENDED TO PROVIDE A BRIEF DESCRIPTION OF YOUR DENTAL PLAN. IF THERE IS ANY CONFLICT BETWEEN THIS BOOKLET AND THE COMPLETE TEXT OF THE PLAN DOCUMENT, THEN THE PLAN DOCUMENTS GOVERN AND SHALL SUPERSEDE THIS BOOKLET.

Dental Benefits Administered by

DELTA DENTAL OF ILLINOIS
111 Shuman Boulevard
Naperville, Illinois 60563

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DEFINITIONS

This Group Dental Plan is subject to the following definitions:

"Approved Fee" or "Approved Amount" means Delta Dental of Illinois allowed fees.

"Benefit Year" means the amount of time the dental plan is in effect. This is shown in the Dental Plan Specifications. The Benefit Year determines when Deductibles must be paid and when waiting periods are met. It also determines any coverage limits for each Covered Individual.

"Covered Individual" means any employee or any Dependent of that employee who enrolls in this Group Dental Plan and who is entitled to receive Dental Benefits, unless and until coverage terminates as provided herein.

"Effective Date of Coverage" means the date an individual meets the required conditions of eligibility and becomes enrolled in this Group Dental Plan.

"Delta Dental PPO Dentist" means a Dentist licensed to practice dentistry and who, by written agreement with Delta Dental of Illinois or another Delta Dental member company, will provide dental services to Covered Individuals in accordance with Delta Dental's Fee Schedules and has agreed to abide by the bylaws, rules and regulations established by Delta Dental.

"Delta Dental Premier Dentist: means a Dentist licensed to practice dentistry and who, by written agreement with Delta Dental of Illinois or another Delta Dental member company, undertakes to provide dental services to Covered Individuals in accordance with the terms and conditions established by Delta Dental and to abide by the by-laws, rules and regulations established by Delta Dental.

"Dental Benefits" means those dental procedures or services which are listed in this booklet subject to the exclusions, terms and conditions contained in this booklet.

"Dental Benefits Booklet" means this booklet issued to an Enrolled Employee setting forth the terms and conditions of this Group Dental Plan. Employer shall be responsible for distributing this booklet to Enrolled Employees.

"Dentist" means a licensed Dentist legally entitled to practice dentistry at the time and in the place services are provided.

"Dental Provider" means a provider that is licensed to provide dental services at the time and location services are provided.

"Eligibility Date" means the date an employee or Dependent may become enrolled in this Group Dental Plan.

"Enrolled Employee" means an employee who has satisfied the requirements for eligibility as set forth herein and who enrolls in this Group Dental Plan and makes the required contribution, if any.

"Group Plan Commencement Date" means the date this Group Dental Plan begins pursuant to the date designated in the Dental Plan Specifications.

"Maximum Plan Allowance" means the amount that a Delta Dental Premier Dentist agrees contractually to accept as full payment for covered procedures. The Maximum Plan Allowance is calculated as a percentile of billed fees.

"Non-Delta Dental Network Dental Provider" means a Dental Provider who is not a Delta Dental PPO or Delta Dental Premier Dentist. Non-Network Dental Providers have not agreed to accept Delta Dental of Illinois' Approved Fee as full payment of their services and may bill the patient the difference between his/her fee and Delta Dental of Illinois' benefit payment.

"Proof of Claim" means the required documentation set forth in the section titled *Required Documentation* as well as all the requested information indicated on Delta Dental of Illinois' claim form.

GENERAL INFORMATION ON HOW THE PLAN WORKS

Under this Group Dental Plan, you are free to go to the Dental Provider of your choice; however, you will receive greater benefits if you go to a Delta Dental PPO Dentist. A list of Delta Dental PPO Dentists is available on the Delta Dental of Illinois website www.deltadentalil.com.

The level of covered Dental Benefits paid under this Group Dental Plan depends on whether you go to (1) a Delta Dental PPO Dentist, (2) a Non-Delta Dental PPO Dentist who is a Delta Dental Premier Dentist, or (3) a Non-Network Dental Provider. See the Schedule of Dental Benefits for a description of the payment levels for each of the above categories of Dental Providers.

This Group Dental Plan will pay Delta Dental PPO Dentists and Delta Dental Premier Dentists directly and the right to receive that payment shall not be assignable. If your Dental Provider is a Non-Network Dental Provider, you will be paid directly and the right to receive that payment shall not be assignable.

HOW TO FILE A CLAIM

TO USE YOUR GROUP DENTAL PLAN, FOLLOW THESE STEPS

(1) Please read this Dental Benefits Booklet carefully in order to familiarize yourself with the benefits and provisions of this Group Dental Plan.

(2) Please be sure that the information portion of the claim form includes the following:

- (a) the enrolled employee's full name and address;
- (b) the enrolled employee's ID number;
- (c) the name and date of birth of the person receiving dental treatment; and
- (d) the group name and number.

(3) If your Dental Provider is not familiar with this Group Dental Plan or has any questions regarding this Group Dental Plan, he/she may contact Delta Dental of Illinois, 111 Shuman Boulevard, Naperville, Illinois 60563; telephone (1-800) 323-1743.

(4) If your Dental Provider expects that the total fees for your dental treatment will exceed $200, then Delta Dental of Illinois recommends that a request for a pre-treatment estimate of plan benefits be submitted, prior to treatment, to Delta Dental of Illinois, P.O. Box 5402, Lisle, Illinois 60532, so that you and your Dental Provider are aware of the coverage afforded under this Group Dental Plan prior to services being rendered. This request must show your dental needs and a description of the procedures and services which the treating Dental Provider plans to perform, including the actual fees to be charged for each procedure or service.

(5) Delta Dental of Illinois will review the request for a pre-treatment estimate of plan benefits and the required documentation (as set forth in the section titled *Required Documentation*) submitted by the treating Dental Provider in order to determine the level of payment under this Group Dental Plan. A pre-treatment estimate does not take into account other coverage you may have; Delta Dental of Illinois coordinates its benefits with another group dental plan after treatment has been completed.

(6) After your treating Dental Provider has completed the dental services outlined in the Predetermined Benefit Voucher, this voucher is to be resubmitted to Delta Dental of Illinois indicating the date each dental procedure or service was rendered. If procedures or services are rendered after 90 days from the date this Group Dental Plan issued its payment determination, as outlined in the Predetermined Benefit Voucher, the claim must be submitted to Delta Dental of Illinois with the required documentation set forth in the section titled *Required Documentation*. This Proof of Claim should be furnished within 90 days after you have received the Dental Benefit.

(7) If a request for a pre-treatment estimate of plan benefits is not submitted in advance as requested, this Group Dental Plan reserves the right to make a determination of the level of payment, taking into account the provisions of this Group Dental Plan. A determination made by Delta Dental of Illinois imposes no restrictions on the method of diagnosis or treatment by a treating Dental Provider and only relates to the level of payment which this Group Dental Plan is required to make.

(8) Submission of a request for a pre-treatment estimate of plan benefits before treatment commences is not requested for:

(a) procedures and services where the total fees are less than $200;

(b) emergency examination and treatment for accidental injuries; emergency treatment for relief of pain when not related to a final procedure; and

(c) oral surgery necessitated as a result of an injury.

DENTAL BENEFITS

This Group Dental Plan will pay for those dental services or procedures listed in the Schedule of Dental Benefits. Benefit payments are subject to any applicable Deductible, waiting periods and coverage limits listed in the Dental Plan Specifications.

The Dental Benefits furnished under this Group Dental Plan are limited and defined as set forth in the Schedule of Dental Benefits. A request for a pre-treatment estimate of plan benefits, accompanied by any required documentation, should be submitted to Delta Dental of Illinois for payment determination before services are rendered. A determination made by Delta Dental of Illinois imposes no restrictions on the method of diagnosis or treatment by a treating Dental Provider and only relates to the level of payment which this Group Dental Plan is required to make.

Not all dental services and procedures are covered under this Group Dental Plan. See the Schedule of Dental Benefits for a list of services and procedures not covered.

LEVEL OF DENTAL BENEFITS

The level of covered Dental Benefits under this Group Dental Plan depends on whether a Covered Individual goes to (1) a Delta Dental PPO Dentist, (2) a Non-Delta Dental PPO Dentist who is a Delta Dental Premier Dentist, or (3) a Non-Network Dental Provider. See the Schedule of Dental Benefits for a description of the benefit levels for each of the above categories of Dental Providers.

REQUIRED DOCUMENTATION

The following information must be submitted to Delta Dental of Illinois with every request for a pre-treatment estimate of plan benefits or claim for payment for the listed Dental Benefits. In the absence of this information or the requested information indicated on Delta Dental of Illinois' claim form, this Group Dental Plan will be unable to render a benefit determination.

Full Mouth Series of Radiographs: This Group Dental Plan requires the submission of full mouth radiographs with every claim for non-surgical periodontics, surgical periodontics and complete dentures.

Full Arch Periapical Radiographs: This Group Dental Plan requires the submission of full arch periapical radiographs with every claim for osseous fractures and fixed partial and removable dentures.

Periapical Radiographs: This Group Dental Plan requires the submission of periapical radiographs with every claim for surgical extractions, endodontics (post-operative radiographs), cast restorations and space maintainers.

Narrative: This Group Dental Plan requires the submission of a narrative with every claim for consultations, emergency examinations, palliative treatment and general anesthesia.

Histopathology/Hospital Report: This Group Dental Plan requires the submission of a histopathology and/or hospital report with every claim for biopsies and the surgical excision of tissue.

GENERAL PROVISIONS

NOTICE AND PROOF OF DENTAL CLAIMS

Written notice and proof of claim is to be furnished to Delta Dental of Illinois within 90 days after the Covered Individual has received a Dental Benefit.

Failure to furnish this Proof of Claim within this 90 day time period shall not invalidate or reduce any claim if the Covered Individual provides a reasonable explanation of this failure to file a timely claim. IN NO EVENT WILL EMPLOYER BE LIABLE FOR ANY NOTICE OR PROOF OF CLAIM WHICH IS SUBMITTED TO DELTA DENTAL OF ILLINOIS MORE THAN ONE YEAR AFTER THE COVERED INDIVIDUAL HAS RECEIVED DENTAL SERVICES FOR THAT CLAIM. No action shall lie against employer unless, as a condition precedent thereto, the Covered Individual shall have fully complied with the notice and Proof of Claim provisions contained in this Dental Benefits Booklet.

COORDINATION OF BENEFITS

The purpose of this Group Dental Plan is to help you meet the cost of needed dental care or treatment. It is not intended that anyone receive benefits greater than actual expenses incurred. In no event will payment under this plan exceed the amount which would have been allowed if dental coverage did not exist.

If a Covered Individual is entitled to coverage under two or more policies or prepaid health care plans, then the covered Dental Benefits of this Group Dental Plan shall be paid as follows:

(1) The benefits of the plan which covers the person directly as the employee and not as a Dependent will be determined before those of the plan which covers the person as a Dependent.

(2) Except as set forth in paragraph (3), when two or more plans cover the same child as a Dependent of different parents:

(a) The benefits of the plan of the parent whose birthday, excluding year of birth, falls earlier in a year will be determined before those of the plan of the parent whose birthday, excluding year of birth, falls later in that year; but

(b) If both parents have the same birthday, the benefits of the plan which covered the parent for a longer period of time will be determined before those of the plan which covered the parent for a shorter period of time.

However, if a plan subject to the rule based on the birthday of the parents as stated above coordinates with an out-of-state plan which has a rule based upon the gender of the parent, and if as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

(3) If two or more plans cover a Dependent child of divorced or separated parents, benefits of the child will be determined in this order:

(a) First, the plan of the parent with custody of the child;

(b) Second, the plan of the spouse of the parent with custody of the child; and

(c) Third, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obliged to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before that entity has that actual knowledge.

But if the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules as set forth in paragraph (2).

(4) The benefits of a plan which covers a person as an employee who is neither laid off nor retired, or as that employee's Dependent, will be determined before those of a plan which covers that person as a laid off or retired employee or as that employee's Dependent. If the other plan is not subject to this rule, and if, as a result, the plans do not agree on the order of benefits, this paragraph shall not apply.

(5) If none of the rules in paragraphs (1), (2), (3) or (4) determine the order of benefits, the benefits of the plan which covered an employee for a longer period of time will be determined before those of the plan which covered that person for the shorter period of time.

If this Group Dental Plan provides only secondary coverage, it shall not be obligated to make payment until Delta Dental of Illinois receives a copy of the primary carrier's proof of payment and calculation of benefits.

Where an individual has dual coverage, this Group Dental Plan shall not be charged with a greater amount than the amount for which it would be liable if such dual coverage did not exist. In any event, the benefits under both plans shall not total more than the Dental Provider's billed fees.

DISPUTED CLAIMS PROCEDURE

Prior Approval of Benefits: This group dental plan *does not require* prior approval of dental services. Nonetheless, a Covered Individual and his/her treating Dental Provider may request a a pre-treatment estimate of benefits to obtain advance information on the plan's possible coverage of services before they are rendered. Payment, however, is limited to the benefits that are covered under this plan and is subject to any applicable Deductible, waiting periods, annual and lifetime coverage limits as well as this plan's payment policies.

Notice of Adverse Benefit Determination: If a claim is denied in whole or in part, Delta Dental of Illinois shall notify the enrollee of the denial in writing, by issuing an Explanation of Benefits (sometimes referred to as an adverse benefit determination), within 30 days after the claim is filed, unless special circumstances require an extension of time, not exceeding 15 days, for processing. Delta Dental of Illinois will notify the treating Dental Provider as well by issuing an Explanation of Payment. If an extension is necessary, Delta Dental of Illinois shall notify the enrollee and the treating Dental Provider of the extension and the reason it is necessary within the original 30-day period. If an extension is needed because either the enrollee or the treating Dental Provider did not submit information necessary to decide the claim, the notice of extension shall specifically describe the required information. The claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Explanation of Benefits Form: This form includes the following information:

(1) Through the use of a reference code (numerical code), a statement of the specific reason(s) why the claim was denied, in whole or in part, including specific plan provisions on which the denial is based and a description of any additional information needed in order to perfect the claim as well as the reason why such information is necessary;

(2) A description of Delta Dental of Illinois' appeal process and the time limits applicable to the process, including a statement of the enrollee's right, if this group dental plan is subject to the federal law known as the Employee Retirement Income Security Act ("ERISA"), to bring a civil action under ERISA following an adverse benefit determination;

(3) If applicable, through the use of a reference code (numerical code), a statement of the specific rule, guideline or protocol relied upon in making the adverse benefit determination;

(4) If applicable, through the use of a reference code (numerical code), a statement of the relevant scientific or clinical judgment, if the adverse benefit determination is related to dental necessity, experimental treatment or other similar exclusion or limitation.

Request for Appeal of Adverse Benefit Determination: If the enrollee disagrees with Delta Dental of Illinois' adverse benefit determination, he/she may appeal this determination to the Reevaluation Committee of Delta Dental of Illinois within 180 days following receipt of the adverse benefit determination. The appeal must be in writing and must state why it is believed that Delta Dental of Illinois' benefit decision was incorrect. The denial notice, as well as any other documents or information bearing on the claim, should accompany the appeal request. The Reevaluation Committee's review of the claim upon appeal will take into account all comments, documents, records or other information submitted by the claimant, regardless of whether such information was submitted or considered in the initial benefit determination.

Upon request, Delta Dental of Illinois will provide, free of charge, reasonable access to and copies of all documents, records and other information relevant to the denied claim.

Reevaluation Committee's Review: The review shall be conducted by a person who is neither the individual who made the initial claim denial nor the subordinate of such individual. If the review is of an adverse benefit determination based in whole or in part on a determination related to dental necessity, experimental treatment or a clinical judgment in applying the terms of the contract, the Reevaluation Committee shall consult with a Dental Provider who has appropriate training and experience in the pertinent field of Dental Providerry and who is neither the dental consultant who made the initial claim denial nor the subordinate of such consultant. The Reevaluation Committee shall provide upon request by the claimant the name of any dental consultant whose advice was obtained in connection with the claim denial, whether or not that advice was relied upon in making the initial benefit determination.

Notice of Review Decision: The Reevaluation Committee shall notify the claimant in writing of its decision on the appeal within 60 days of receipt of the request for review.

If the Reevaluation Committee upholds the adverse benefit determination on appeal, the notice to the claimant shall include the following information:

(1) Through the use of a reference code (numerical code), a statement of the specific reason(s) for the adverse determination, including specific plan provisions upon which the determination is based;

(2) A statement that reasonable access to and copies of all documents, records and other information relevant to the denied claim are available free of charge upon request;

(3) A statement of the claimant's right, if this group dental plan is subject to the federal law known as the Employee Retirement Income Security Act ("ERISA"), to bring a civil action under ERISA;

(4) If applicable, through the use of a reference code (numerical code), a statement of the specific rule, guideline or protocol relied upon in making the adverse determination;

(5) If applicable, through the use of a reference code (numerical code), a statement of the relevant scientific or clinical judgment, if the adverse benefit determination is related to dental necessity, experimental treatment or other similar exclusion or limitation.

Employer's Review of Claims for Eligibility Reasons: Notwithstanding the above procedures, employer has the right to review and override all claim determinations related to eligibility or loss of eligibility, whether said claims are approved or denied.

APPENDIX A

SCHEDULE OF DENTAL BENEFITS

This Group Dental Plan agrees, SUBJECT TO THE EXCLUSIONS, TERMS AND CONDITIONS SET FORTH HEREIN, to pay for those dental services or procedures listed in this Schedule. Benefit payments are subject to any applicable Deductibles, waiting periods and coverage limits listed in the Dental Plan Specifications.

Members may go to any licensed Dental Provider when they need dental care. Whatever Dental Provider is chosen, some level of benefits will be available. The level of covered benefits paid under this Group Dental Plan depends on whether a Covered Individual goes to a Delta Dental PPO Dentist, a Delta Dental Premier Dentist, or a Non-Network Dental Provider. Regardless of the type of Dental Provider, this Group Dental Plan pays the designated co-payment percentage as set forth in this Schedule. The following outlines the level of Dental Benefits paid.

DELTA DENTAL PPO DENTIST: Dentists participating in the Delta Dental PPO network agree to accept Delta Dental's PPO fees for services as payment in full for dental services. This means they cannot bill members for the difference between what they charge for a dental service and what Delta Dental of Illinois allows for Delta Dental PPO Dentist. This requirement for Delta Dental PPO network dentist protects members from unexpected charges and saves members 30 percent on average for a dental service. However, Your dental plan bases all claim payments on the Delta Dental PPO fee. Because of this, Delta Dental Premier® and Non-Network Dental Providers can bill You for charges above the allowed Delta Dental PPO fee.

DELTA DENTAL PREMIER DENTIST: Delta Dental Premier serves as a "safety net" to Delta Dental PPO. Delta Dental Premier Dentists agree to accept Delta Dental Premier Maximum Plan Allowances as payment in full for dental services. You will pay more out-of-pocket with a Delta Dental Premier Dentist compared to a Delta Dental PPO Dentist, but you will likely save more with a Delta Dental Premier Dentist compared to a Non-Network Dental Provider.

DELTA DENTAL PPO and PREMIER DENTISTS: For Delta Dental PPO and Delta Dental Premier Dentists, the Approved Amount is Delta Dental's allowed Delta Dental PPO fees or Delta Dental Premier Maximum Plan Allowances. The Allowed Amount is the amount determined by calculating Delta Dental's payment obligation under your group dental plan. Often, the Approved Amount and Allowed Amount are the same. If they differ, it's because of provisions in the Group Dental Plan. You are only responsible for the applicable Deductible and patient Co-Payment amount plus the difference between the Approved Amount and Allowed Amount. In addition, Delta Dental pays Delta Dental PPO and Premier Dentists directly, so you do not have to pay the whole bill up front and wait for reimbursement.

NON-NETWORK DENTAL PROVIDER: If the Dental Provider you select does not participate in the Delta Dental PPO network or the Delta Dental Premier network, you will be responsible for the difference between your Dental Provider's submitted amount and Delta Dental's payment. The amount Delta Dental uses to calculate its payment, that is the Allowed Amount, will be the lesser of the submitted amount and Maximum Plan Allowance. Delta Dental has the right to make any benefit payment either to you or directly to the Non-Network Dental Provider. Delta Dental is specifically authorized by you to determine to whom any benefit payment should be made. At the Dental Provider's discretion, you may have to pay the entire bill in advance.

The benefits furnished under this Group Dental Plan are limited and defined as set forth in the Schedule of Dental Benefits. A request for a pre-treatment estimate of contract benefits, accompanied by any required documentation, should be submitted to DDIL for payment determination before services are rendered. A determination made by Delta Dental of Illinois imposes no restrictions on the method of diagnosis or treatment by a treating Dental Provider and only relates to the level of payment which this Group Dental Plan is required to make.

APPENDIX A
SCHEDULE OF DENTAL BENEFITS

If the co-payment percentage shown is "N/A", that procedure is not covered under this group dental plan.
See Appendix B for exclusions.

	Co-Payment Percentage			Deductible Applies		
Procedure	**Delta Dental PPO**	**Delta Dental Premier**	**Out-of-network**	**Delta Dental PPO**	**Delta Dental Premier**	**Out-of-network**
DIAGNOSTIC SERVICES						
Oral evaluations (includes limited – problem focused and re-evaluation – limited, problem focused)	100%	100%	100%	N	N	N
Comprehensive oral evaluation – new or established patient: *twice per benefit year*	100%	100%	100%	N	N	N
Detailed and extensive oral evaluation – problem focused, by report: *twice per benefit year*	100%	100%	100%	N	N	N
Comprehensive periodontal evaluation – new or established patient: *twice per benefit year*	100%	100%	100%	N	N	N
Periodic oral evaluations: *twice per benefit year*	100%	100%	100%	N	N	N
Intra-oral – periapical radiographs	100%	100%	100%	N	N	N
Bitewing x-rays: *once per benefit year*	100%	100%	100%	N	N	N
Complete full mouth x-rays: *once in a 36-month interval. A full-mouth x-ray includes bitewing x-rays. Panoramic x-rays in conjunction with any other x-ray or any combination of intraoral x-rays on the same date of service may be alternated to a full mouth x-ray. One full-mouth x-ray, or one panoramic x-ray is a covered benefit in a 36-month interval*	100%	100%	100%	N	N	N
Diagnostic casts: *when rendered more than 30 days prior to definitive treatment*.	100%	100%	100%	N	N	N
Pulp vitality tests: *once per visit*	100%	100%	100%	N	N	N
Screening or assessment of a patient *once in a 12-month interval*	100%	100%	100%	N	N	N

If additional detailed or comprehensive oral evaluations are billed by the same Dental Provider the level of benefits will be limited to that of a periodic oral evaluation.

Detailed or comprehensive oral evaluations count toward the benefit year maximum of two oral evaluations.

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-network	Delta Dental PPO	Delta Dental Premier	Out-of-network
PREVENTIVE SERVICES						
Dental prophylaxis (cleaning): *twice per benefit year**	100%	100%	100%	N	N	N
Topical fluoride applications: *twice per calendar year, for Dependent children under age 19*	100%	100%	100%	N	N	N
Space maintainers: *covered when they replace prematurely lost teeth for covered persons under age 19*	100%	100%	100%	N	N	N
Recementation of space maintainers: *once per lifetime for covered persons under age 19*	100%	100%	100%	N	N	N
Sealants: *applied once per tooth to the occlusal surface of molars that are free of decay and restorations; for Dependent children under age 19*	100%	100%	100%	N	N	N

With an indicator of surgical or non-surgical treatment of periodontal disease, a participant is eligible for up to two additional dental visits in a benefit year for periodontal maintenance or adult prophylaxis

**With an indicator for diabetes, high risk cardiac conditions, kidney failure or dialysis conditions, or special healthcare needs, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year.*
**With an indicator for periodontal disease, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.*
**With an indicator for suppressed immune system conditions or cancer-related chemotherapy and/or radiation, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.*
**With an indicator for pregnancy, the enrollee will be eligible for one additional cleaning (prophylaxis or periodontal maintenance) during the time of pregnancy.*

RESTORATIVE SERVICES						
Amalgam and resin-based composite fillings *once per surface in a 12-month interval*.	80%	80%	80%	Y	Y	Y
Onlays (permanent teeth only)	50%	50%	50%	Y	Y	Y
Crowns and ceramic restorations (permanent teeth only)	50%	50%	50%	Y	Y	Y
Recementation of inlays, onlays, partial coverage restorations, cast or prefabricated posts and cores and crowns	80%	80%	80%	Y	Y	Y
Crown repair	80%	80%	80%	Y	Y	Y
Prefabricated stainless steel crowns	50%	50%	50%	Y	Y	Y
Sedative filling	50%	50%	50%	Y	Y	Y
Pin retention	50%	50%	50%	Y	Y	Y
Cast or prefabricated post and core; core build-up	50%	50%	50%	Y	Y	Y

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-network	Delta Dental PPO	Delta Dental Premier	Out-of-network

When an inlay is requested or placed, the level of benefits will be limited to that of an amalgam filling.

When multiple pins are requested or placed, the level of benefits will be limited to one pin per tooth.

Sedative fillings are a covered Dental Benefit once per tooth per lifetime.

Crowns are allowed once every 8 years

ENDODONTIC SERVICES						
Pulpal and root canal therapy	80%	80%	80%	Y	Y	Y

When endodontic therapy is performed on primary teeth, the level of benefits will be limited to that of a pulpotomy, except where radiographs indicate there is no permanent successor tooth and the primary tooth demonstrates sufficient intact root structure.

Retreatment of root canal therapy within 24 months of initial treatment is not a covered benefit.

When incomplete endodontic therapy is billed because the patient has been referred to an endodontist for completion of endodontic treatment, the level of benefits will be limited to that of a pulpal debridement.

Pulpal therapy (resorbable filling) is a covered Dental Benefit once per tooth per lifetime.

SURGICAL PERIODONTIC SERVICES						
Gingivectomy or gingivoplasty; gingival flap procedure	80%	80%	80%	Y	Y	Y
Clinical crown lengthening - hard tissue	80%	80%	80%	Y	Y	Y
Osseous surgery (including flap entry and closure)	80%	80%	80%	Y	Y	Y
Guided tissue regeneration, per site	80%	80%	80%	Y	Y	Y
Bone replacement and soft tissue grafts	80%	80%	80%	Y	Y	Y

Surgical periodontics are allowed once every 3-years

Surgical Periodontic Services are only covered when performed in association with natural teeth.

NON-SURGICAL PERIODONTIC SERVICES						
Periodontal scaling and root planing	80%	80%	80%	Y	Y	Y
Full mouth debridement to enable comprehensive evaluation and diagnosis: *once per lifetime*	80%	80%	80%	Y	Y	Y
Periodontal maintenance: *twice per benefit year**	80%	80%	80%	Y	Y	Y

Periodontal therapy includes treatment for diseases of the gums and bone supporting the teeth once per quadrant in any 24-month interval.

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-network	Delta Dental PPO	Delta Dental Premier	Out-of-network

With an indicator of surgical or non-surgical treatment of periodontal disease, a participant is eligible for up to two additional dental visits in a benefit year for periodontal maintenance or adult prophylaxis.

**With an indicator for diabetes, high risk cardiac conditions, kidney failure or dialysis conditions, or special healthcare needs, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year.*
**With an indicator for periodontal disease, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.*
**With an indicator for suppressed immune system conditions or cancer-related chemotherapy and/or radiation, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.*
**With an indicator for pregnancy, the enrollee will be eligible for one additional cleaning (prophylaxis or periodontal maintenance) during the time of pregnancy.*

REMOVABLE PROSTHODONTIC SERVICES						
Complete and partial dentures	50%	50%	50%	Y	Y	Y
Adjustments to complete and partial dentures *twice every 12-months*	80%	80%	80%	Y	Y	Y
Repairs to complete and partial dentures *once every 24-months*	80%	80%	80%	Y	Y	Y
Replace missing or broken teeth	80%	80%	80%	Y	Y	Y
Add tooth or clasp to existing partial denture *once per lifetime*	80%	80%	80%	Y	Y	Y
Replace all teeth and acrylic on cast metal framework *once per lifetime*	80%	80%	80%	Y	Y	Y
Denture rebase: *once in a 3-year period*	80%	80%	80%	Y	Y	Y
Denture reline: *once in a 3-year period*	80%	80%	80%	Y	Y	Y
Tissue conditioning *once in a 12-month period*	80%	80%	80%	Y	Y	Y
Stayplate *once in a 5-year interval*	50%	50%	50%	Y	Y	Y

FIXED PROSTHODONTIC SERVICES (BRIDGES)						
Pontics	50%	50%	50%	Y	Y	Y
Fixed partial denture retainers - inlays/onlays (inlays/onlays placed as abutments, i.e., to retain or support fixed partial dentures)	50%	50%	50%	Y	Y	Y
Fixed partial denture retainers – crowns (crowns placed as abutments, i.e., to retain or support fixed partial dentures)	50%	50%	50%	Y	Y	Y
Recement fixed partial denture *once per lifetime*	80%	80%	80%	Y	Y	Y
Fixed partial denture (bridge) repair *once per lifetime*	80%	80%	80%	Y	Y	Y
Cast or prefabricated post and core; core build-up	50%	50%	50%	Y	Y	Y

	Co-Payment Percentage			Deductible Applies		
Procedure	**Delta Dental PPO**	**Delta Dental Premier**	**Out-of-network**	**Delta Dental PPO**	**Delta Dental Premier**	**Out-of-network**

When a fixed partial denture is requested or placed and three or more teeth are missing in a dental arch, the level of benefits will be limited to that of a removable partial denture. The placement of any additional appliance in the same arch within 96 months following placement of the initial appliance is not a covered benefit.

When the edentulous space between teeth exceeds 100% of the size of the original tooth, the level of benefits will be limited to that of one pontic per missing tooth.

When a fixed partial denture and a removable partial denture are requested or placed in the same arch, the level of benefits will be limited to that of a removable partial denture.

If, in the construction of a prosthodontic appliance, personalized or special techniques including, but not limited to, tooth supported dentures, precision attachments or stress breakers, are elected, the level of benefits will be limited to that of a conventional prosthodontic appliance.

When a porcelain/ceramic inlay is requested or placed as an abutment (i.e., to retain or support a fixed partial denture), the level of benefits will be limited to that of a cast metal inlay.

ORAL SURGERY						
Simple extractions	80%	80%	80%	Y	Y	Y
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	80%	80%	80%	Y	Y	Y
Removal of impacted tooth – soft tissue	80%	80%	80%	Y	Y	Y
Removal of impacted tooth – partially bony	80%	80%	80%	Y	Y	Y
Removal of impacted tooth – completely bony	80%	80%	80%	Y	Y	Y
Tooth reimplantation/stabilization of accidentally evulsed or displaced tooth and/or alveolus	80%	80%	80%	Y	Y	Y
Surgical access of an unerupted tooth	80%	80%	80%	Y	Y	Y
Biopsy of oral tissue; brush biopsy	80%	80%	80%	Y	Y	Y
Alveoloplasty - per quadrant	80%	80%	80%	Y	Y	Y
Surgical excision of soft tissue lesions	80%	80%	80%	Y	Y	Y
Surgical excision of intra-osseous lesions	80%	80%	80%	Y	Y	Y
Other covered surgical/repair procedures: removal of exostosis, torus palatinus or torus mandibularis; incision and drainage of abscess - intraoral soft tissue; frenulectomy or frenuloplasty; excision of hyperplastic tissue or pericoronal gingiva; surgical reduction of osseous or fibrous tuberosity.	80%	80%	80%	Y	Y	Y

Oral Surgery includes extractions and other listed oral surgery procedures (including pre- and post-operative care) only when provided in a Dental Provider's office.

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-network	Delta Dental PPO	Delta Dental Premier	Out-of-network
ADJUNCTIVE GENERAL SERVICES						
Palliative (emergency) treatment of dental pain - minor procedure	80%	80%	80%	Y	Y	Y
Deep sedation/general anesthesia: *when provided by a Dental Provider in conjunction with Oral Surgery (surgical procedures) other than simple extractions.*	80%	80%	80%	Y	Y	Y
Intravenous conscious sedation/analgesia: *when provided in conjunction with Oral Surgery (surgical procedures) other than simple extractions.*	80%	80%	80%	Y	Y	Y
Consultations	100%	100%	100%	N	N	N
Athletic mouthguard *once every 24-months for Dependent children under age 19*	N/A	N/A	N/A	N/A	N/A	N/A
OTHER						
Treatment of fractures of facial bones	80%	80%	80%	Y	Y	Y
Implants *once every 8-years for covered persons age 16 and older*	50%	50%	50%	Y	Y	Y
Non-surgical treatment of temporomandibular joint (TMJ) dysfunction: occlusal orthotic appliance *once every 5-years*, occlusal guard *once per lifetime*, occlusal guard reline/repair *once per lifetime*, occlusal guard adjustment *once in a 12-month interval*	50%	50%	50%	Y	Y	Y
Occlusal adjustment *once in a 12-month interval*	50%	50%	50%	Y	Y	Y
ORTHODONTIC SERVICES						
Treatment necessary for the proper alignment of teeth	N/A	N/A	N/A	N/A	N/A	N/A

If specialized techniques (for example, clear or "Invisalign" braces) are elected, a Delta Dental PPO dentist is not obligated to accept the scheduled fee as full payment and may charge the patient any difference in cost between the optional method and a conventional appliance in addition to scheduled copayment amounts.

APPENDIX B
EXCLUSIONS

EXCLUSIONS THAT APPLY TO DIAGNOSTIC SERVICES:

- Pulp vitality tests billed in conjunction with any service except for an emergency exam or palliative treatment are not a covered benefit.

EXCLUSIONS THAT APPLY TO PREVENTIVE SERVICES:

- Recementation of a space maintainer within six months of initial placement is not a covered benefit.

EXCLUSIONS THAT APPLY TO RESTORATIVE SERVICES:

- Fillings are not a covered benefit when crowns are allowed for the same teeth.

- Replacement of any existing cast restoration (crowns, onlays, ceramic restorations) with any type of cast restoration within 96 months following initial placement of existing restoration is not a covered benefit.

- Replacement of a stainless steel crown with any type of cast restoration is not a covered benefit by the same office within 24 months following initial placement.

- A cast restoration is a covered benefit only in the presence of radiographic evidence of decay or missing tooth structure. Restorations placed for any other purpose, including, but not limited to, cosmetics, abrasion, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformations of teeth, or the anticipation of future fractures, are not a covered benefit.

- When there is radiographic evidence of sufficient vertical height (more than three millimeters above the crestal bone) on a tooth to support a cast restoration, a crown build-up is not a covered benefit.

- The repair of any component of a cast restoration is not a covered benefit.

- Recementation of inlays, onlays, partial coverage restorations, cast and prefabricated posts and cores and crowns by the same office within six months of initial placement is not a covered benefit.

- Additional procedures to construct a new crown under the existing partial denture framework within six months following initial placement is not a covered benefit.

- When a sedative filling is requested or placed on the same date as a permanent filling, the sedative filling is not a covered benefit.

- Major restoratives for a patient under age 12 is not a covered benefit.

EXCLUSIONS THAT APPLY TO ENDODONTIC SERVICES:

- When a benefit has been issued for endodontic services, retreatment of the same tooth within two years is not a covered benefit.

- Endodontic procedures performed in conjunction with complete removable prosthodontic appliances are not a covered benefit.

EXCLUSIONS THAT APPLY TO PERIODONTIC SERVICES:

- Guided tissue regeneration billed in conjunction with implantology, ridge augmentation/sinus lift, extractions or periradicular surgery/apicoectomy is not a covered benefit.

- Crown lengthening or gingivoplasty, if not performed at least four weeks prior to crown preparation, is not a covered benefit.

- Bone replacement grafts performed in conjunction with extractions or implants are not a covered benefit.

- Periodontal splinting to restore occlusion is not a covered benefit.

EXCLUSIONS THAT APPLY TO PROSTHODONTIC SERVICES:

- Replacement of any existing prosthodontic appliance (cast restorations, fixed partial dentures, removable partial dentures, complete denture) with any prosthodontic appliance within 96 months following initial placement of existing appliance is not a covered benefit.

- When a fixed partial denture and a removable partial denture are requested or placed in the same arch, the fixed partial denture is not a covered benefit.

- Reline or rebase of an existing appliance within six months following initial placement is not a covered benefit.

- Fixed or removable prosthodontics for a patient under age 16 is not a covered benefit.

- When the edentulous (toothless) space between teeth is less than 50% of the size of the missing tooth, a pontic is not a covered benefit.

EXCLUSIONS THAT APPLY TO ORAL SURGERY:

- Mobilization of an erupted or malpositioned tooth to aid eruption or placement of a device to facilitate eruption of an impacted tooth performed in conjunction with other oral surgery is not a covered benefit.

GENERAL EXCLUSIONS THAT APPLY TO ALL PROCEDURES:

Coverage is NOT provided for:

- Services compensable under Worker's Compensation or Employer's Liability laws.

- Services provided or paid for by any governmental agency or under any governmental program or law, except as to charges which the person is legally obligated to pay. This exception extends to any benefits provided under the U.S. Social Security Act and its Amendments.

- Services performed to correct developmental malformation including, but not limited to, cleft palate, mandibular prognathism, enamel hypoplasia, and fluorosis and congenitally missing teeth. This exclusion does not apply to *newborn infants.*

- Services performed for purely cosmetic purposes, including, but not limited to, tooth-colored veneers, bonding, porcelain restorations and microabrasion. Orthodontic care benefits shall fall within this exclusion unless such benefits are provided by endorsement.

- Charges for services completed prior to the date the person became covered under this program.

- Services for anesthetists or anesthesiologists.

- Temporary procedures.

- Any procedure requested or performed on a tooth when radiographs indicate that less than 40% of the root is supported by bone.

- Services performed on non-functional teeth (second or third molar without an opposing tooth).

- Services performed on deciduous (primary) teeth near exfoliation.

- Drugs or the administration of drugs, except for general anesthesia and intravenous conscious sedation.

- Procedures deemed experimental or investigational by the American Dental Association, for which there is no procedure code, or which are inconsistent with Current Dental Terminology coding and nomenclature.

- Surgical services with respect to any disturbance of the temporomandibular joint (jaw joint).

- Procedures that Delta Dental considers to be included in the fees for other procedures. For such procedures, a separate payment will not be made by this group dental plan. A Dentist in the Delta Dental PPO or Delta Dental Premier network may not bill the patient for such procedures.

- The completion of claim forms and submission of required information, not otherwise covered, for determination of benefits.

- Infection control procedures and fees associated with compliance with Occupational Safety and Health Administration (OSHA) requirements.

- Broken appointments.

- Services and supplies for any illness or injury occurring on or after the *covered individual's effective date of coverage* as a result of war or an act of war.

- Services for, or in connection with, an intentional self-inflicted injury or illness while sane or insane, except when due to domestic violence or a medical (including both physical and mental) health condition.

- Services and supplies received from either a *covered individual's* or *covered individual's* spouse's relative, any individual who ordinarily resides in the *covered individual's* home or any such similar person.

- Services for, or in connection with, an injury or illness arising out of the participation in, or in consequence of having participated in, a riot, insurrection or civil disturbance or the commission of a felony.

- Charges for services for inpatient/outpatient hospitalization.

- Services or supplies for oral hygiene or plaque control programs.

- Services or supplies to correct harmful habits.

APPENDIX C
DENTAL PLAN SPECIFICATIONS

CONTRACT NUMBER: 20246

GROUP PLAN COMMENCEMENT DATE: January 1, 2026

BENEFIT YEAR: January 1st through December 31st

ELIGIBILITY REQUIREMENTS:

Eligibility for coverage under this group dental plan shall be determined by the Employer. Refer to the BMO U.S. Health and Welfare Benefit Plan for Active Employees or BMO U.S. Health and Welfare Benefit Plan for Retirees at www.bmousbenefits.com.

DEDUCTIBLE:

Procedures listed in the Schedule of Dental Benefits for which a Deductible applies are subject to a $50.00 Deductible per Covered Individual per Benefit Period, not to exceed $150.00 per family unit per Benefit Period.

COVERAGE LIMITS:

The maximum coverage limit per Covered Individual per Benefit Period is $1,000.00.

COVERAGE LIMITS – TMJ:

Benefits for treatment of non-surgical temporomandibular joint (TMJ) dysfunction are subject to a separate Lifetime Maximum of $1,000.00 per Covered Individual.

ENHANCED BENEFITS PROGRAM:

Delta Dental of Illinois' Enhanced Benefits Program enhances coverage for individuals who have specific health conditions that can be positively affected by additional oral health care.

Benefits are specific to the type of health condition and may include additional cleanings and/or applications of topical fluoride for individuals who qualify. Individuals with disabilities may also qualify for additional services. The costs of the additional treatments will be applied to a member's annual maximum.

Members who qualify include but may not be limited to:

- Individuals with periodontal (gum) disease.
- Individuals with diabetes.
- Individuals who are pregnant.
- Individuals with cardiac conditions.
- Individuals with kidney failure or who are undergoing dialysis.
- Individuals who are undergoing cancer-related chemotherapy and/or radiation.
- Individuals with suppressed immune systems, including individuals with HIV, autoimmune conditions, organ recipients, and/or stem cell (bone marrow) recipients.

- Individuals with disabilities, including individuals with physical, medical, developmental and/or cognitive needs, such as autism, Alzheimer's disease, Down syndrome, spinal cord injuries, and other conditions where modifications are necessary to provide the best oral health treatment possible.

If one of these conditions applies to you, sign up for enhanced benefits today by visiting the Subscriber section of www.deltadentalil.com or call 800-323-1743.

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