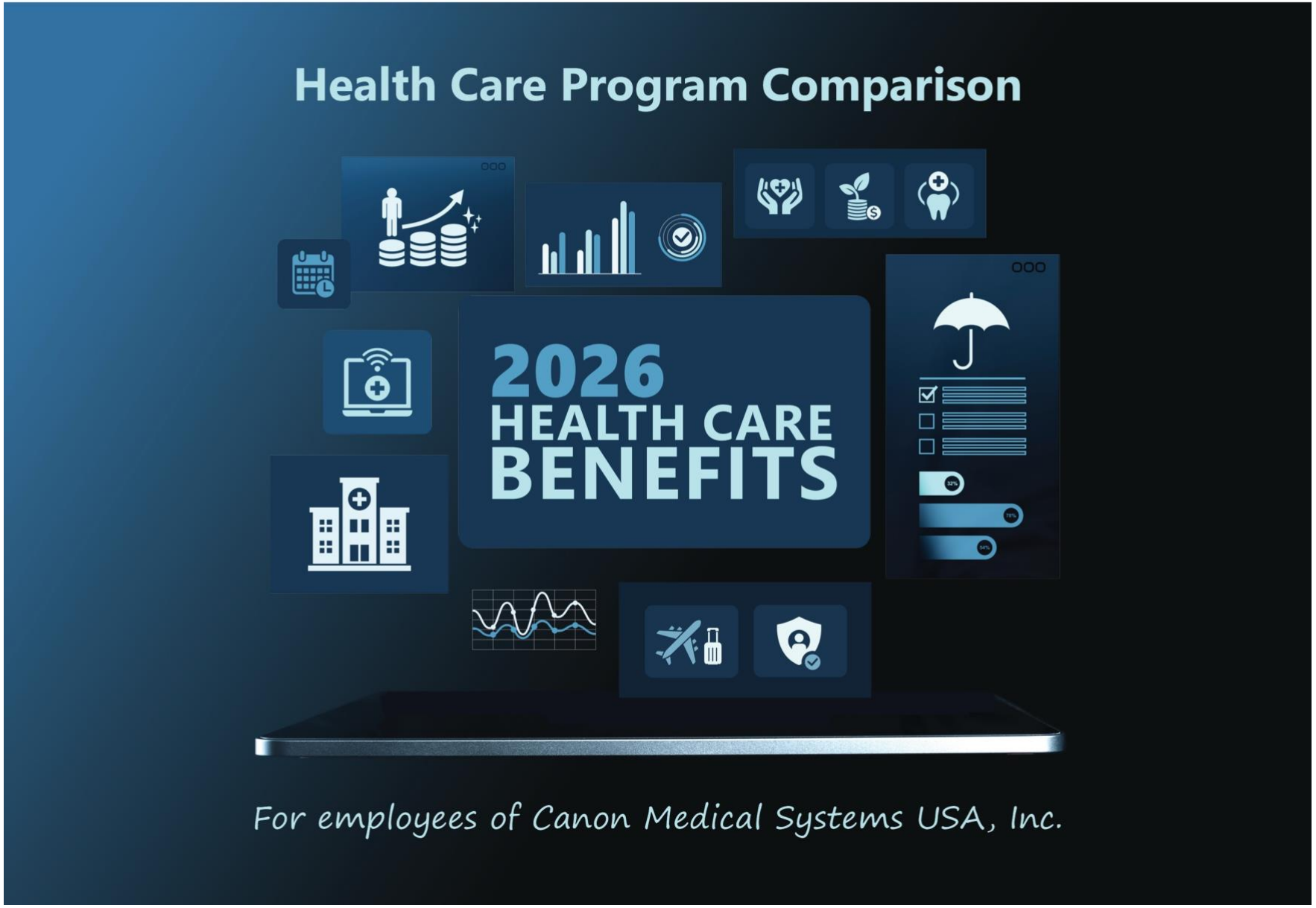

The following charts are for summary purposes only. If any information in this summary conflicts with the official plan documents, the plan documents will always govern. References to a spouse and/or children also apply to a domestic partner and/or a domestic partner's child(ren), with the exception of contributions for coverage—see the domestic partner rate sheet.

Canon

Your 2026 Medical Benefits

	EPO PLAN	CDHP BASIC	CDHP SELECT	CDHP PREMIER
YOUR CONTRIBUTIONS FOR COVERAGE				
Employee Only	$31.00 per pay period ($744.00 per year)	$34.50 per pay period ($828.00 per year)	$61.00 per pay period ($1,464.00 per year)	$106.00 per pay period ($2,544.00 per year)
Employee + Spouse/DP	$71.00 per pay period ($1,704.00 per year)	$79.00 per pay period ($1,896.00 per year)	$137.00 per pay period ($3,288.00 per year)	$238.50 per pay period ($5,724.00 per year)
Employee + Child	$46.50 per pay period ($1,116.00 per year)	$52.00 per pay period ($1,248.00 per year)	$91.00 per pay period ($2,184.00 per year)	$159.50 per pay period ($3,828.00 per year)
Employee + Children (2+)	$64.00 per pay period ($1,536.00 per year)	$71.00 per pay period ($1,704.00 per year)	$124.00 per pay period ($2,976.00 per year)	$217.00 per pay period ($5,208.00 per year)
Employee + Spouse/DP + Children (1 or 2)	$98.00 per pay period ($2,352.00 per year)	$109.00 per pay period ($2,616.00 per year)	$188.50 per pay period ($4,524.00 per year)	$330.00 per pay period ($7,920.00 per year)
Employee + Spouse/DP + Children (3+)	$128.00 per pay period ($3,072.00 per year)	$142.50 per pay period ($3,420.00 per year)	$244.50 per pay period ($5,868.00 per year)	$428.00 per pay period ($10,272.00 per year)
ABOUT THE PLANS				
How the Plans Work	All services and prescription drugs must be received within the plan's exclusive provider network. There are no benefits for out-of-network care except in an emergency. The plan is administered by Aetna.	These plans are Consumer-Driven High Deductible plans that combine traditional PPO medical coverage with a tax-advantaged Health Savings Account (HSA). If you're not eligible for an HSA, the Company will establish a Health Reimbursement Account (HRA) for you instead. The plans are administered by Aetna. Each year in January, CMSU funds a base Company contribution into your HSA or HRA that is used to pay for eligible health care expenses. After you meet your plan's annual deductible, the plan will begin to pay its share of benefits (see coinsurance on page 3). **About the HSA** • If you have an HSA, you can also choose to contribute your own money to the account on a pre-tax basis, up to the IRS annual limit. • When you have a health care expense, you can use your HSA funds to offset your deductible or let it build for future health care expenses—it's your choice. Your HSA can also be used for eligible dental and vision expenses. • HSA balances roll over from year to year. • The HSA and its funds are owned by you. If you leave CMSU, your HSA goes with you. **About the HRA** • The IRS only permits employer contributions to an HRA. • When you have a medical or prescription drug expense, your HRA is automatically used to pay your deductible and applicable copays and coinsurance. Your HRA will continue to be used until its funds are depleted. • HRA balances roll over from year to year only if you remain employed and enrolled in your CMSU medical plan. • The HRA and its funds are owned by CMSU. If you leave the Company, your HRA does not go with you.	
Name of Provider Network	Aetna Premier Care Network Plus (APCN+)	Aetna Choice POS II (Open Access)		

	EPO PLAN	CDHP BASIC	CDHP SELECT	CDHP PREMIER
Provider Choice	You may only use providers who participate in the Aetna Premier Care Network Plus (APCN+) network.	You have the choice to use any licensed provider, though you will pay less out of pocket if you use network providers. It is your responsibility to verify if your providers (i.e., doctors, labs, facilities) are participating in the network. Charges from network and non-network providers are subject to Aetna's Maximum Allowed Amount for that service. Network fees are paid based on negotiated rates, which are less than the Maximum Allowed Amount, and you will not be responsible for more than the negotiated rate. Non-network charges that exceed the Maximum Allowed Amount are not covered by the plan and are your responsibility to pay—on top of any other amount you owe.		
Member Services	800-635-3364			
Group Number	187455			
Website	Aetna member website: www.aetna.com Aetna online directory: https://www.aetnadocfind.com/2026-apcn-plus-oaas/	www.aetna.com If you are not enrolled, you may locate network providers at Aetna's website. In the "Continue as a guest" section, enter your location and click "Search", and under the "Aetna Open Access Plans" section, click "Aetna Choice POS II (Open Access)", then click the "Continue" button.		
CVS Virtual Care (if you are enrolled in a Company medical plan)	For non-emergency health issues when your regular doctor isn't available, use CVS Virtual Care. This telemedicine service connects you to U.S.-based board-certified doctors for face-to-face conversations on your computer or mobile device. There is no charge for virtual visits. The providers at CVS Virtual Care are able to make diagnoses and send prescriptions to your local pharmacy. CVS Virtual Care is available 24/7, 365 days. Get started at their website.			
Claim Forms	No claim forms required	When you use network providers, your claims will be filed for you. For non-network providers, you may need to pay for the expense at the time of service and file a claim for reimbursement. For non-network claim forms, visit Benefits Source. Keep in mind that if a non-network provider charges more than Aetna's Maximum Allowed Amount, the excess charge isn't covered by the plan—you will owe that amount.		
HSA/HRA CONTRIBUTIONS				
Employer HSA/HRA Contributions	N/A	CMSU deposits money into your HSA/HRA each January. If you complete the annual wellness incentive, the Company will also deposit an earned wellness incentive. HSA/HRA employer contributions are prorated if you join the plan after January 1.		
		Base employer contribution:	Earned wellness incentive:	Employer base + earned wellness contribution:
Employee Only Employee + Spouse/DP Employee + Child Employee + Children (2+) Employee + Spouse/DP + Children (1 or 2) Employee + Spouse/DP + Children (3+)	N/A	$250 $500 $500 $500 $500 $500	$500 $1,000* $500 $500 $1,000* $1,000*	$750 $1,500* $1,000 $1,000 $1,500* $1,500*
		*Up to this amount, if both employee and spouse/domestic partner complete the required annual wellness incentive steps		
2026 IRS Maximum HSA Contribution (HSA participants only)	N/A	HSA participants may contribute up to the annual IRS limits. The 2026 IRS limit for HSA contributions is $4,400 for "Employee only" and $8,750 for all other coverage tiers. CMSU's employer contribution counts toward the IRS maximum, so you can contribute any amount to your HSA up to the remainder. Your HSA contributions will be made through convenient pre-tax semi-monthly payroll deductions. If you (and your spouse/domestic partner, if applicable) complete the wellness incentive, you may contribute up to $3,650 for "Employee Only", $7,750 for "Employee + Child" or "Employee + Children (2+), or $7,250 for all other coverage tiers. If you do not complete the annual wellness incentive, you can make the same pre-tax contributions to your HSA as noted above, and make up the additional $500 or $1,000 non-earned wellness incentive amount as a lump sum deposit to your account directly with Voya Financial (for a total of $4,150 for "Employee only" and $8,250 for all other coverage tiers).		

	EPO PLAN	CDHP BASIC	CDHP SELECT	CDHP PREMIER
GENERAL PROVISIONS				
Annual Deductible	The annual deductible is the amount you pay for covered services before the plan begins to pay benefits.	The annual deductible is the amount you pay for covered services and prescription drugs before the plan begins to pay benefits.		
	$3,000 per person/$6,000 per family	In-network: Employee Only coverage level: $3,000 per person All other coverage levels: $3,400 per person and $6,000 per family Out-of-network: $5,000 per person/$10,000 per family	In-network: $2,500 employee only/$5,000 family Out-of-network: $4,000 employee only/$8,000 family	In-network: $2,000 employee only/$4,000 family Out-of-network: $4,000 employee only/$8,000 family
How the Deductible Works	When a family member meets the individual deductible, benefits will begin for that person. The family deductible can be met with any combination of expenses incurred by any family member, except that one person can never incur deductible expenses above the individual deductible limit.	When a family member meets the individual deductible, benefits will begin for that person. The family deductible can be met with any combination of expenses incurred by any family member, except that one person can never incur deductible expenses above the individual deductible limit.	The full family deductible must be met before the plan begins to pay benefits for any family member's expenses—even if one person has met the individual deductible. The family deductible can be met by one family member or by a combination of family members.	
Coinsurance (the percentage the plan pays for covered services; you pay the remainder, if applicable)	Plan pays 70% of contracted fee after deductible for services that require a deductible	In-network: Plan pays 70% of contracted fee after deductible for most services Out-of-network: Plan pays 50% of Aetna's Maximum Allowed Amount after deductible for most services	In-network: Plan pays 80% of contracted fee after deductible for most services Out-of-network: Plan pays 50% of Aetna's Maximum Allowed Amount after deductible for most services	In-network: Plan pays 90% of contracted fee after deductible for most services Out-of-network: Plan pays 60% of Aetna's Maximum Allowed Amount after deductible for most services
Health Accounts and the Deductible	N/A	If you have an HSA—you have the choice to use it to pay down your deductible or save it for future health care expenses. If you have an HRA—your HRA is automatically used to pay down your deductible or medical/Rx copays or coinsurance. After your entire HRA is used, if there is a remaining deductible balance, this is the amount you must pay to meet your deductible for the year.		

	EPO PLAN	CDHP BASIC	CDHP SELECT	CDHP PREMIER
Out-of-Pocket Maximum	The out-of-pocket maximum is the most you have to pay in a calendar year for medical services and prescription drugs. Once you reach this amount, the plan pays 100% of eligible medical and prescription drug expenses for the rest of the calendar year. The out-of-pocket maximum includes your deductible plus the coinsurance you pay up to the amounts shown below. It does not include non-notification penalties and charges that aren't covered by the plan.	The out-of-pocket maximum is the most you have to pay in a calendar year for medical services and prescription drugs. Once you reach this amount, the plan pays 100% of eligible medical and prescription drug expenses for the rest of the calendar year. The out-of-pocket maximum includes your deductible plus the coinsurance you pay up to the amounts shown below. It does not include non-notification penalties, charges above the Maximum Allowed Amount, and charges that aren't covered by the plan.		
	$6,000 per person/$12,000 per family	In-network: $6,000 per person/$12,000 per family Out-of-network: $8,500 per person/$17,000 per family	In-network: $5,000 per person/$8,500 per family Out-of-network: $7,000 per person/$14,000 per family	In-network: $3,000 per person/$6,000 per family Out-of-network: $6,000 per person/$12,000 per family
How the Out-of-Pocket Maximum Works	When a family member meets the individual out-of-pocket maximum, the plan will pay 100% benefits for that person for the rest of the year. It can be met with any combination of expenses incurred by any family member, except that one person can never incur expenses above the individual out-of-pocket maximum limit. When the family out-of-pocket maximum is met, the rest of the family will receive 100% benefits for the rest of the calendar year.	When a family member meets the individual out-of-pocket maximum, the plan will pay 100% benefits for that person for the rest of the year. It can be met with any combination of expenses incurred by any family member, except that one person can never incur expenses above the individual out-of-pocket maximum limit. When the family out-of-pocket maximum is met, the rest of the family will receive 100% benefits for the rest of the calendar year.	If you cover one or more dependents, the family out-of-pocket maximum applies, not the individual out-of-pocket maximum. This means that the plan will pay 100% benefits after the family out-of-pocket maximum is satisfied. The family out-of-pocket maximum can be met by one family member or by a combination of family members. When the family out-of-pocket maximum is met, all family members will receive 100% benefits for the rest of the calendar year.	
Inpatient Hospital Copay	None	In-network: $250/admission Out-of-network: $500/admission	In-network: $250/admission Out-of-network: $500/admission	None
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited

	EPO PLAN	CDHP BASIC	CDHP SELECT	CDHP PREMIER
PRESCRIPTION DRUGS (**network coverage only**; maximum and minimum amounts are per prescription, all amounts you pay go toward your OOP)				
Medications Covered at No Cost to You	All prescription drugs listed on Aetna's Health Care Reform Preventive Drug List.			
Network Retail (up to a 31-day supply)				
Preventive drugs listed on Aetna's Preventive Drug List	Your deductible is waived and you pay the following amounts: • Generic: $20 copay • Preferred brand: $40 copay • Non-preferred brand: $60 copay	Your deductible is waived and you pay the following tiered copay or coinsurance amounts: • Generic: $10 copay • Preferred brand: 25% coinsurance, $25 min., $75 max. • Non-preferred brand: 40% coinsurance, $40 min., $100 max.		
Non-preventive drugs listed on Aetna's Prescription Drug List	Your deductible is waived and you pay the following amounts: • Generic: $20 copay • Preferred brand: $40 copay • Non-preferred brand: $60 copay	You pay the full cost of the medication until your annual deductible is satisfied, then you pay the following tiered copay or coinsurance amounts: • Generic: $10 copay • Preferred brand: 25% coinsurance, $25 min., $75 max. • Non-preferred brand: 40% coinsurance, $40 min., $100 max.		
Network Mail Order (90-day supply)				
Preventive drugs listed on Aetna's Preventive Drug List	Your deductible is waived and you pay the following amounts: • Generic: $40 copay • Preferred brand: $80 copay • Non-preferred brand: $120 copay	Your deductible is waived and you pay the following tiered copay or coinsurance amounts: • Generic: $25 copay • Preferred brand: 25% coinsurance, $50 min., $150 max. • Non-preferred brand: 40% coinsurance, $80 min., $200 max.		
Non-preventive drugs listed on Aetna's Prescription Drug List	Your deductible is waived and you pay the following amounts: • Generic: $40 copay • Preferred brand: $80 copay • Non-preferred brand: $120 copay	You pay the full cost of the medication until your annual deductible is satisfied, then you pay the following tiered copay or coinsurance amounts: • Generic: $25 copay • Preferred brand: 25% coinsurance, $50 min., $150 max. • Non-preferred brand: 40% coinsurance, $80 min., $200 max.		
Prior Authorization	Your physician will need to obtain prior authorization from Aetna before prescribing certain drugs that have risks of side effects or drug interactions, potential for incorrect use or abuse, or alternatives that may cost you less and work better. Your doctor and/or pharmacist will coordinate with Aetna if a prescribed drug needs prior authorization.			
Specialty Medications (31-day supply)	Specialty medications must always be filled at a CVS Specialty Pharmacy. Specialty medications are managed by PrudentRx, who works with drug manufacturers to keep your costs down through manufacturer copay card assistance. For specialty medications that are listed on PrudentRx's Drug List, you pay 30% until you meet your deductible, then the plan will cover it in full. Specialty medications that are not covered on the PrudentRx list will process at regular plan copays and coinsurance amounts. Refer to the PrudentRx Drug List to see if a drug is covered, or call PrudentRx at 800-578-4403 Monday-Friday, between 8:00am and 8pm Eastern Time.			
Quantity Limits	Certain medications have a quantity limit on how much can be dispensed each time the prescription is filled. You will be notified if this is the case for your prescription.			

	EPO PLAN	CDHP BASIC	CDHP SELECT	CDHP PREMIER
OFFICE VISITS AND PREVENTIVE CARE				
Percentage amounts shown below represent the amount the plan pays after you meet the deductible, unless otherwise noted — you pay the remaining percentage (coinsurance). Flat dollar amounts represent the amount you pay at the time of service (your copay).				
Physician Office Visits (includes office surgery if part of the office visit)	Primary care: $40 copay Specialist: $80 copay	In-network: 70% after deductible Out-of-network: 50% after deductible	In-network: 80% after deductible Out-of-network: 50% after deductible	In-network: 90% after deductible Out-of-network: 60% after deductible
Adult Preventive Care (physician office visits, X-ray, and lab associated with preventive services)	100% (deductible waived)	In-network: 100% (deductible waived) Out-of-network: 50% after deductible	In-network: 100% (deductible waived) Out-of-network: 50% after deductible	In-network: 100% (deductible waived) Out-of-network: 60% after deductible
Well Child Preventive Care (subject to Aetna guidelines)	100% (deductible waived)	In-network: 100% (deductible waived) Out-of-network: 50% after deductible	In-network: 100% (deductible waived) Out-of-network: 50% after deductible	In-network: 100% (deductible waived) Out-of-network: 60% after deductible
Immunizations for Primary Prevention (flu shot, allergy, childhood immunizations)	100% (deductible waived)	In-network: 100% (deductible waived) Out-of-network: 50% after deductible	In-network: 100% (deductible waived) Out-of-network: 50% after deductible	In-network: 100% (deductible waived) Out-of-network: 60% after deductible
HbA1c testing for Diabetes Prevention and Monitoring	100% (deductible waived)	In-network: 100% (deductible waived) Out-of-network: 50% after deductible	In-network: 100% (deductible waived) Out-of-network: 50% after deductible	In-network: 100% (deductible waived) Out-of-network: 60% after deductible
HOSPITAL SERVICES				
Penalty for Not Pre-Notifying Aetna	None	In-network: N/A Out-of-network: $250	In-network: N/A Out-of-network: $250	In-network: N/A Out-of-network: $250
Hospital Room and Board	70% after deductible	In-network: 70% after deductible and $250 copay (per admission) Out-of-network: 50% after deductible and $500 copay (per admission)	In-network: 80% after deductible and $250 copay (per admission) Out-of-network: 50% after deductible and $500 copay (per admission)	In-network: 90% after deductible Out-of-network: 60% after deductible
Anesthesiologists, Radiologists, and Pathologists	70% after deductible	70% after deductible	80% after deductible	90% after deductible
Attending Physicians, Surgeons, Assistant Surgeons, Specialists, and Consulting Physicians	70% after deductible	In-network: 70% after deductible Out-of-network: 50% after deductible	In-network: 80% after deductible Out-of-network: 50% after deductible	In-network: 90% after deductible Out-of-network: 60% after deductible

	EPO PLAN	CDHP BASIC	CDHP SELECT	CDHP PREMIER
EMERGENCY SERVICES (in or out of the network)				
Hospital Emergency Room	70% after deductible	70% after deductible and $100 copay (copay waived if admitted)	80% after deductible and $100 copay (copay waived if admitted)	90% after deductible and $100 copay (copay waived if admitted)
Physician Services in Emergency Room	70% after deductible	70% after deductible	80% after deductible	90% after deductible
Urgent Care Facility	70% after deductible	70% after deductible	80% after deductible	90% after deductible
Ambulance	70% after deductible	70% after deductible	80% after deductible	90% after deductible
OTHER SERVICES AND SUPPLIES				
Diagnostic X-ray and Lab Services (pre-authorization required for certain advanced imaging procedures or additional $250 copay)	70% after deductible	In-network: 70% after deductible Out-of-network: 50% after deductible	In-network: 80% after deductible Out-of-network: 50% after deductible	In-network: 90% after deductible Out-of-network: 60% after deductible
Mental Health and Substance Abuse	70% after deductible	In-network: 70% after deductible (for inpatient stays, you pay a $250 copay per admission) Out-of-network: 50% after deductible (for inpatient stays, you pay a $500 copay per admission) Pre-authorization required for out-of-network inpatient/outpatient services	In-network: 80% after deductible (for inpatient stays, you pay a $250 copay per admission) Out-of-network: 50% after deductible (for inpatient stays, you pay a $500 copay per admission) Pre-authorization required for out-of-network inpatient/outpatient services	In-network: 90% after deductible Out-of-network: 60% after deductible Pre-authorization required for out-of-network inpatient/outpatient services
Outpatient Surgery—Aetna (outside office visit)	70% after deductible	In-network: 70% after deductible Out-of-network: 50% after deductible	In-network: 80% after deductible Out-of-network: 50% after deductible	In-network: 90% after deductible Out-of-network: 60% after deductible
Outpatient Surgery—Lantern network only	100% after deductible	100% after deductible	100% after deductible	100% after deductible
Acupuncture (24 visits/year)	70% after deductible	In-network: 70% after deductible Out-of-network: 50% after deductible	In-network: 80% after deductible Out-of-network: 50% after deductible	In-network: 90% after deductible Out-of-network: 60% after deductible
Chiropractic (24 visits/year, then subject to medical necessity)	70% after deductible	In-network: 70% after deductible Out-of-network: 50% after deductible	In-network: 80% after deductible Out-of-network: 50% after deductible	In-network: 90% after deductible Out-of-network: 60% after deductible
Injections to Treat a Condition	70% after deductible	In-network: 70% after deductible Out-of-network: 50% after deductible	In-network: 80% after deductible Out-of-network: 50% after deductible	In-network: 90% after deductible Out-of-network: 60% after deductible
Allergy Testing and Treatment	70% after deductible	In-network: 70% after deductible Out-of-network: 50% after deductible	In-network: 80% after deductible Out-of-network: 50% after deductible	In-network: 90% after deductible Out-of-network: 60% after deductible

	EPO PLAN	CDHP BASIC	CDHP SELECT	CDHP PREMIER
Fertility Treatment and Medication	70% after deductible	In-network: 70% after deductible Out-of-network: N/A	In-network: 80% after deductible Out-of-network: N/A	In-network: 90% after deductible Out-of-network: N/A
	Lifetime maximums for all medical plans: $40,000 for fertility treatment and $20,000 for fertility medications			
Medical Genetic Testing To determine efficacy of Plavix, Tamoxifen, Warfarin, and Gleevec; also for Oncotype-DX test BRCA test	70% after deductible	In-network: 100% (deductible waived) Out-of-network: 50% after deductible	In-network: 100% (deductible waived) Out-of-network: 50% after deductible	In-network: 100% (deductible waived) Out-of-network: 60% after deductible
Hearing Aids (one hearing aid per ear each time hearing aid prescription changes – medical necessity required)	70% after deductible	In-network: 70% after deductible Out-of-network: 50% after deductible	In-network: 80% after deductible Out-of-network: 50% after deductible	In-network: 90% after deductible Out-of-network: 60% after deductible
Home Health Care and Private Duty Nursing (120 combined visits/year)	70% after deductible	In-network: 70% after deductible Out-of-network: 50% after deductible	In-network: 80% after deductible Out-of-network: 50% after deductible	In-network: 90% after deductible Out-of-network: 60% after deductible
Skilled Nursing Facility (120 days/year)	70% after deductible	In-network: 70% after deductible Out-of-network: 50% after deductible	In-network: 80% after deductible Out-of-network: 50% after deductible	In-network: 90% after deductible Out-of-network: 60% after deductible
Hospice	70% after deductible	In-network: 70% after deductible Out-of-network: 50% after deductible	In-network: 80% after deductible Out-of-network: 50% after deductible	In-network: 90% after deductible Out-of-network: 60% after deductible
Physical Therapy, Physical Medicine, Speech Therapy, and Occupational Therapy (60 visits per year, 36 visits per year for pulmonary or cardiac rehabilitation	70% after deductible	In-network: 70% after deductible Out-of-network: 50% after deductible	In-network: 80% after deductible Out-of-network: 50% after deductible	In-network: 90% after deductible Out-of-network: 60% after deductible
Hinge Health Digital Exercise Therapy	Hinge Health is a free, virtual physical therapy program that helps relieve pain in your back, knees, shoulders, hips, pelvic floor, and more. When you sign up, Hinge Health will assess your condition and match you to a care team for a personalized treatment plan. Hinge Health is available to CMSU employees and dependents who are 18 years or older. To learn more and sign up, visit Hinge Health.			
Temporomandibular Joint Syndrome (not covered if dental in nature)	70% after deductible	In-network: 70% after deductible Out-of-network: 50% after deductible	In-network: 80% after deductible Out-of-network: 50% after deductible	In-network: 90% after deductible Out-of-network: 60% after deductible

Your 2026 Dental Benefits

Delta Dental administers the DPO/PPO. The chart below provides an overview of how the dental plan works, and the benefits the plan pays for covered services. Percentage amounts shown below represent the amount the plan pays after you meet the deductible, unless otherwise noted.

Delta Dental PPO		
Your Contributions for Coverage		
Employee Only	$3.50 per pay period ($84.00 per year)	
Employee + Spouse/DP	$9.50 per pay period ($228.00 per year)	
Employee + Child	$7.00 per pay period ($168.00 per year)	
Employee + Children (2+)	$9.00 per pay period ($216.00 per year)	
Employee + Spouse/DP + Children (1 or 2)	$13.50 per pay period ($324.00 per year)	
Employee + Spouse/DP + Children (3+)	$18.00 per pay period ($432.00 per year)	
How the Plan Works	Delta Dental offers two networks: DPO/PPO and DeltaPremier. Delta's DPO/PPO network offers deeper discounts than the DeltaPremier network, which will translate into lower out-of-pocket costs. DeltaPremier dentists don't discount their fees, but they have agreed to not charge more than Delta's allowed amounts (UCR). If you use out-of-network dentists, you will not be reimbursed for charges that exceed Delta's UCR amounts.	
Claim Forms	Network dentists file claim forms for you. If you visit a non-network provider, you may need to pay for services up front and submit your claim to Delta Dental.	
Annual Maximum Benefit	$2,000 per person (Note: Preventive, diagnostic, and orthodontic care do not count toward your annual maximum benefit, so your benefit goes farther).	
	Network Dentists	**Non-Network Dentists**
Annual Deductible	$50 per person/$150 per family	$100 per person/$300 per family
Preventive & Diagnostic Care Routine exams (two per year); cleanings (three per year); fluoride application for children under 19 (two per year); bite-wing x-rays (one per year for adults and two per year for children to age 19); sealants for children to age 19 (one every three years)	100% (deductible waived)	100% of UCR (deductible waived)
	Preventive and diagnostic care services do not count toward your annual maximum benefit. **Additional benefits during pregnancy:** The plan will pay for one additional oral exam and either one additional routine cleaning or one additional periodontal scaling and root planing per quadrant. You or your dentist must provide written confirmation of your pregnancy when the claim is submitted.	
Basic Restorative Care Fillings, one complete x-ray series every 12 months, simple extractions and oral surgery, root canal therapy, general anesthesia, periodontics (except surgery), and endodontics.	80% after deductible	80% of UCR after deductible
Major Restorative Care Crowns, dentures, bridges, dental implants, periodontal surgery, complex oral surgery, and surgery for impacted teeth.	50% after deductible	50% of UCR after deductible
Orthodontia for Children and Adults Orthodontic care does not count toward the annual maximum benefit	50% (deductible waived)	50% of UCR (deductible waived)
	$2,000 orthodontia lifetime maximum benefit	

Your 2026 Vision Benefits

Vision coverage is provided through VSP, which has an extensive network of doctors. When you use a VSP doctor, eligible services are covered at no cost up to the plan allowance after you pay a $15 copayment. To find a VSP provider, visit www.vsp.com. You may also visit a non-VSP provider; however, you pay the entire cost at the time you receive services and you will need to file a claim for reimbursement.

Vision Plan		
Your Contributions for Coverage		
Employee Only	$3.50 per pay period ($84.00 per year)	
Employee + Spouse/DP	$6.50 per pay period ($156.00 per year)	
Employee + Child	$7.00 per pay period ($168.00 per year)	
Employee + Children (2+)	$7.00 per pay period ($168.00 per year)	
Employee + Spouse/DP + Children (1 or 2)	$11.50 per pay period ($276.00 per year)	
Employee + Spouse/DP + Children (3+)	$11.50 per pay period ($276.00 per year)	
	VSP Providers	**Non-VSP Providers**
Copayment	You pay $15 for exam and glasses	The plan reimburses you up to plan allowances
Exam (once every 12 months[1])	Plan pays 100%	The plan reimburses you up to $50
Lenses (once every 12 months[1])	Plan pays 100% for standard types of lenses, including polycarbonate lenses for dependent children. Progressive lenses and other lens enhancements are available at a discount.	The plan reimburses you up to $50 for single vision lenses, $75 for bifocal lenses and progressive lenses, $100 for trifocal lenses
Elective Contacts (once every 12 months[1] in lieu of lenses and frames) If you choose contacts, you will be eligible to purchase a frame 12 months from the date you purchased your contacts	Plan pays up to $150 allowance for the contacts and the contact lens exam (fitting and evaluation); you receive 15% off the cost of the contact lens exam for the amount over your allowance.	The plan reimburses you up to $105
Frames Once every 24 months[1]	Plan pays 100% up to $200 allowance for a wide selection of standard frames and featured frame brands, and you receive 20% off the amount over your allowance. The plan also pays a $100 allowance for Costco frames.	The plan reimburses you up to $70

[1]Frequency is based on your last date of service.

Extra Benefits, Discounts, and Savings—VSP Providers Only

- Suncare benefit: $200 allowance for ready-made non-prescription sunglasses instead of prescription glasses or contacts. If you choose non-prescription sunglasses, you'll be eligible for lenses or contacts 12 months and frames 24 months from the date you purchased your sunglasses.
- Discounts on additional glasses: 30% off additional glasses and sunglasses, including lens enhancements, from the same VSP doctor on the same day as your vision exam OR 20% off from any VSP doctor within 12 months of your last exam.
- Laser vision discounts: Average 15% off the regular price or 5% off the promotional price. After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.
- Routine retinal screening: You pay no more than $39 on routine retinal screening as an enhancement to a vision exam from a VSP doctor.
- Primary Eyecare: $20 copay per visit for treatment and diagnosis of eye conditions like pink eye and vision loss and monitoring of cataracts, glaucoma, and diabetic retinopathy.