

Summary of Dental Plan Benefits

IMA FINANCIAL GROUP, INC. (High Option)

Account Benefit Plan ID# 50914-02

Effective for January 1, 2026

	Benefit % Paid				
	Delta Dental PPO	Delta Dental Premier	**Out-of-Network		
MAXIMUM BENEFIT(S) PER PERSON: The Maximum Benefit for all Covered Services, excluding Diagnostic and Preventive Services, but including Implant Services, for each Enrollee in any one Calendar Year is: Two Thousand Dollars (\$2,000.00) . The Maximum Benefit for Orthodontic Services for each Enrollee is: Two Thousand Dollars (\$2,000.00) during such person's lifetime. Payment for the Orthodontic Services shall not be included in determining the Maximum Benefit for each Calendar Year.	100%	100%	100%		
DEDUCTIBLE LIMITATIONS: Coverage for Diagnostic and Preventive Services are not subject to any Deductible amount. For all other covered benefits, the Calendar Year Deductible is: \$50x3	80%	80%	80%		
*Healthy Benefits, Healthy Smile, Healthy You – Patients who are pregnant, diabetic, have a suppressed immune system, have kidney failure, are undergoing dialysis, or have a history of periodontal treatment are eligible for up to (2) two additional periodontal cleanings per Calendar Year. To be eligible for the added benefit you must complete a Self-Report form found within the Subscriber Connection at www.deltadentalks.com or by contacting Delta Dental of Kansas' Customer Service at 1-800-234-3375.	80%	80%	80%		
ELIGIBLE CHILDREN AGES: Children are eligible up to the last day of the month in which they turn age twenty-six (26) .	50%	50%	50%		
**Using an Out-of-Network provider may result in higher out of pocket expenses. Refer to your benefit booklet for further information.					
DIAGNOSTIC & PREVENTIVE (Not Subject to Deductible or Maximum)					
				Diagnostic:	Includes the following procedures necessary to evaluate existing dental conditions and the dental care required: <ul style="list-style-type: none"> • <u>Oral evaluations</u> – two (2) times per Calendar Year. • <u>Bitewing x-rays</u> – bitewings two (2) times per Calendar Year for dependents under age eighteen (18) and once (1) each twelve (12) months for adults age eighteen (18) and over. • <u>Full mouth or panoramic x-rays</u> – once (1) each five (5) years.
				Preventive:	Provides for the following: <ul style="list-style-type: none"> • <u>*Prophylaxis (Cleanings)</u> – (all types including periodontal maintenance), two (2) times per Calendar Year. • <u>Topical Fluoride</u> – two (2) times per Calendar Year for dependent children under age nineteen (19). • <u>Space Maintainers</u> – for dependent children under age fourteen (14) and only for premature loss of primary molars. • <u>Sealants</u> – once (1) per tooth per lifetime for dependent children under age sixteen (16) when applied only to permanent molars with no caries (decay) or restorations on the occlusal surface and with the occlusal surface intact.
BASIC (Subject to Deductible)					
				Ancillary:	Provides for one (1) emergency examination per plan year by the Dentist for the relief of pain.
				Oral Surgery:	Provides for extractions and other oral surgery including pre- and post-operative care.
				Regular Restorative:	Provides amalgam (silver) restorations; composite (white) resin restorations on all teeth; and stainless steel crowns for dependents under age twelve (12).
				Endodontics:	Includes procedures for root canal treatments and root canal fillings. When covered, payment for root canal therapy is limited to only once (1) in any twenty-four (24) month period, per tooth.
				Periodontics:	a. Includes procedures and treatment of diseases of the tissues supporting the teeth. Periodontal maintenance, including evaluation, is counted toward the frequency limitation for prophylaxis cleanings. b. Surgical periodontal procedures.
MAJOR (Subject to Deductible)					
				Special Restorative:	When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for individual crowns.
				Prosthodontics:	a. Includes bridges, partial and complete dentures. b. Repairs and adjustments of bridges and dentures. c. Implants.
ORTHODONTICS (Subject to Deductible)					
				Orthodontics:	Includes orthodontic appliances and treatment, interceptive and corrective, for adults and dependent children under age twenty-six (26).
RIGHT START 4 KIDSSM (RS4K):					
					Kids 18 and under receive coverage at 100% for all services covered under the plan. Not subject to deductible. Subject to plan's Annual Maximum, frequencies and limitations apply. Excludes Orthodontics. Must see an in-network dentist or the plan's underlying contract applies including waiting periods, deductibles and coinsurance levels.

This is a summary of benefits only and does not bind Delta Dental of Kansas to any coverage. Subscribers are encouraged to familiarize themselves with the details of their individual plan benefits. Subscribers are responsible for any required copayments, deductibles, or fees for services not covered by their plan at the time services are performed. Please refer to the Description of Dental Care Coverage ("Benefits Booklet") for complete coverage information, including but not limited to any applicable exclusions and limitations. Coverage as described in the employer group's dental benefits contract with Delta Dental of Kansas is binding on all parties and supersedes all other written or oral communications.

