2027 Dental Benefits Summary

PLAN FACTS			
Carrier	Delta Dental	Website	deltadentaloh.com
Member Services	800.524.0149		

WEEKLY PLAN PRICE		
Coverage tier	**Basic**	**Comprehensive**
Partner Only	$3.21	$6.70
Partner + Spouse	$8.34	$17.41
Partner + Child(ren)	$8.18	$17.08
Partner + Family	$9.46	$19.75

KEY PLAN LIMITS			
Provision	**Basic**	**Comprehensive**	**Notes**
Annual deductible — PPO/Premier	$25 individual / $75 family	$50 individual / $150 family	Per plan year
Annual deductible — Out of Network	$50 individual / $150 family	$100 individual / $200 family	Per plan year
Deductible waived	Preventive/diagnostic care and harmful-habit appliances	Preventive/diagnostic care and orthodontics	
Annual maximum — PPO/Premier	$1,250 per person	$1,250 per person	
Annual maximum — Out of Network	$1,000 per person	$1,250 per person	
Pretreatment estimate	$200 PPO/Premier and Out of Network	$200 PPO/Premier and Out of Network	Recommended
Exclusions / limitations	Check with Plan	Check with Plan	

COVERAGE BY SERVICE			
Service category	**Basic**	**Comprehensive**	**Notes**
Preventive & diagnostic	PPO 100% | Premier 70% | OON 70%	PPO 100% | Premier 90% | OON 90%	Exams, cleanings, fluoride, space maintainers, x-rays, sealants, brush biopsy, emergency palliative care and harmful-habit appliances. Exams and cleanings; limited to 2 per year; check with Plan for additional details; frequency and age limitations apply
Basic services	PPO 80% | Premier 60% | OON 30% after deductible	PPO 80% | Premier 70% | OON 60% after deductible	Fillings, routine extractions, periodontics and gingivoplasty/gingivectomy
Emergency treatment for dental pain	PPO 100% | Premier 70% | OON 70%	PPO 100% | Premier 90% | OON 90%	OON benefits subject to Reasonable & Customary limits
Other surgical / protective services	PPO 80% | Premier 60% | OON 30% after deductible	PPO 80% | Premier 70% | OON 60% after deductible	Osseous surgery, oral surgery, dental anesthesia and bruxism occlusal guard (once per lifetime)
Major restorative services	Not covered	PPO/Premier 50% | OON 40% after deductible	Endodontics/root canals, inlays/onlays, crowns, dentures, bridges and implants

ORTHODONTIA			
Provision	**Basic**	**Comprehensive**	**Notes**
Orthodontic treatment	Not covered	50% PPO/Premier and Out of Network	OON subject to Reasonable & Customary limits
Eligible members	Not covered	Children only, under age 19	No adult orthodontia
Lifetime maximum	Not applicable	$1,500 per person	PPO/Premier and Out of Network
Start-up fees	Not covered	Covered with orthodontia treatment plan	

Certain information and/or sections will not appear because this is a summary. If you have questions about a topic that isn't covered in the summary, contact the plan's member services department for additional information. Cintas Corporation is not responsible for the accuracy of this information. If there is a discrepancy between the information displayed on the summary and the official plan documents, the official plan documents will control. Cintas Corporation reserves the right to amend, suspend, or terminate the plan(s) or program(s) at any time.