HOPE GAS, INC. HEALTH AND WELFARE BENEFIT PLAN

DENTAL PLAN

SUMMARY PLAN DESCRIPTION

FOR

EMPLOYEES REPRESENTED

BY

THE UNITED GAS WORKERS' UNION,

LOCAL 69,

UWUA, AFL-CIO

Effective January 1, 2026

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I. INTRODUCTION

The Dental Plan under the Hope Gas, Inc. Health and Welfare Benefit Plan (the "**Health and Welfare Benefit Plan**") is designed to provide Eligible Employees of Hope Gas, Inc. (the "**Company**") and their Eligible Dependents with benefits for covered Dental services, including routine examinations, teeth cleaning, fillings and extractions.

The Summary Plan Description for the Dental Plan consists of this Dental Plan Summary Plan Description (the "**Dental SPD**") and the Additional Information Summary Plan Description for Employees Represented by the United Gas Workers' Union, Local 69, UWUA, AFL-CIO (the "**Additional Information SPD**").

Coverage and benefits under the Dental Plan are provided by Mutual of Omaha and are subject to the terms and conditions of the insurance policy issued by Mutual of Omaha for the Dental Plan, which constitutes and forms a part of the Dental Plan.

Benefits described in this Dental SPD are as in effect on January 1, 2026. The Company may subsequently provide additional materials that supplement, update or amend the Dental SPD or the Additional Information SPD.

II. DENTAL PLAN HIGHLIGHTS

ELIGIBILITY	Employees of the Company who are: • Represented by the United Gas Workers Union Local 69, UWUA, AFL-CIO; and • Regularly scheduled to work an average of 30 hours or more per week.
ENROLLMENT	• Within 31 days after satisfying the eligibility requirements; or • If Dental coverage is not elected within 31 days after initial eligibility, enrollment may be elected during the annual Open Enrollment period or upon a Qualifying Life Event.
WHEN COVERAGE BEGINS	• If enrollment is elected within 31 days of eligibility, coverage is effective as of the eligibility date (e.g. employment date). • If enrollment is not elected within 31 days of eligibility but is elected during an annual Open Enrollment period, coverage is effective as of January 1st following Open Enrollment; however, certain Covered Services will be subject to the Late Enrollment Waiting Period.
COST OF COVERAGE	• If Dental coverage is elected, the Company contributes to the cost of coverage premiums and the employee portion of coverage premiums is deducted from each payroll before federal income tax and, in most cases, before state income tax and Social Security tax are withheld. • The cost of coverage may vary from year to year.
PLAN YEAR	• The Plan Year for the Dental Plan is the 12-month period beginning January 1st and ending the following December 31st
MAXIMUM PLAN YEAR BENEFIT	• The Maximum Plan Year Benefit payable for each covered person is $1,750.
MAXIMUM LIFETIME ORTHODONTIA BENEFIT	• Maximum Lifetime Orthodontia Benefit payable for each covered person is $2,000

III. ELIGIBILITY

ELIGIBLE EMPLOYEES

Regular full-time employees of the Company who are regularly scheduled to work an average of 30 hours or more per week and are represented by The United Gas Workers' Union Local 69, UWUA, AFL-CIO are eligible to enroll for Dental coverage (an "**Eligible Employee**").

ELIGIBLE DEPENDENTS

An Eligible Employee may enroll their Eligible Dependents for Dental coverage. "**Eligible Dependents**" include:

- **Spouse:** an Eligible Employee's legally married spouse or domestic partner.
- **Children**: an Eligible Employee's Children include the following, in each case who is under age 26: (i) natural children, (ii) legally adopted children (including children placed with an Eligible Employee for adoption), (iii) step-children, (iv) foster children, (v) children for whom the Eligible Employee or their Spouse is required to provide coverage pursuant to a Qualified Medical Child Support order or similar order by a court of competent jurisdiction, and (vi) any other child who lives with the Eligible Employee in a parent/child relationship and qualifies as the Eligible Employee's dependent as defined in the Internal Revenue Code.
- **Incapacitated Children:** an Eligible Employee's Children (as defined above) who prior to age 26 became continuously incapable of self-sustaining employment by reason of physical, developmental or intellectual disability or by reason of mental illness.

ELIGIBILITY VERIFICATION

The Plan Administrator may require, upon request, written proof to reasonably verify a dependent's eligibility under the Dental Plan, such as a marriage certificate, birth certificate, adoption certificate and federal tax returns.

IV. ENROLLMENT

NEW HIRE

You can enroll for Dental coverage at any time within 31 days after becoming an Eligible Employee. If you enroll during this initial enrollment period, your coverage will be effective as of the date you are actively at work as an Eligible Employee.

OPEN ENROLLMENT

If you do not enroll for Dental coverage within 31 days after becoming an Eligible Employee, or if you did enroll during this period but wish to change your Dental coverage, you may do so during the annual Open Enrollment period, which takes place each year during the fourth quarter.

Coverage elections during the Open Enrollment period are effective as of January 1st of the following year; however, if you are enrolling for Employee Dental coverage during an Open Enrollment period or enrolling an Eligible Dependent during an Open Enrollment period other than in connection with a Qualifying Life Event, a Late Enrollment Waiting Period of 12 months after enrollment will apply to benefits for Type B Covered Services, Type C Covered Services and Orthodontia Covered Services.

QUALIFYING LIFE EVENTS

If you experience a Qualifying Life Event, you are permitted to change your Dental coverage elections during the middle of a plan year without waiting until the next Open Enrollment period; provided, that you submit to the Plan Administrator written notice within 31 days after the Qualifying Life Event.

An event will be considered a "**Qualifying Life Event**" if it affects your eligibility or your Eligible Dependents' eligibility, including:

- Marriage or registration of domestic partnership;
- Divorce, dissolution of domestic partnership or death of your Spouse;
- Change in your Spouse's employment or eligibility status; or
- A change in the number of your Children (birth, adoption, etc.).

ENROLLMENT OPTIONS

Your Dental coverage enrollment options are:

- Employee only;
- Employee and Spouse;
- Employee and Eligible Dependent Children (including Incapacitated Children); or
- Employee and Eligible Dependents (Spouse + Eligible Dependent Children)

ENROLLMENT PROCESS

You can enroll for Dental coverage by accessing the ADP https:www.workforcenow.adp.com. You can also obtain benefit information and receive other information by accessing the website. For assistance with enrollment, contact Hope Gas Benefits:

Hope Gas, Inc. Benefits
781 Chestnut Ridge Road, Suite 100
Morgantown, WV 26505
(304) 566-2959
Samantha.j.baxter-nard@hopegas.com

V. DENTAL COVERAGE PREMIUMS

If you elect Dental coverage, the employee portion of the coverage premium will be deducted from your pay each payroll period on a before-tax basis for federal income tax and, in most cases, on a before-tax basis for state income tax and Social Security tax.

The Company will pay a portion of the Dental coverage premium. The premium amounts for Dental coverage, including the employee portion and Company portion, are set forth on Appendix A and are subject to change from year-to-year.

VI. DENTAL BENEFITS

Your benefits under the Dental Plan include Covered Services from In-Network Providers and from Out-of-Network Providers. Your benefits are subject to a Maximum Benefit for each Plan Year, and may be subject to a deductible and/or copayment.

IN-NETWORK PROVIDERS

Covered Dental services from an In-Network Provider are at in-network rates. To locate an In-Network Provider near you, please go to www.MutualofOmaha.com/dental.

If covered Dental services are provided by an In-Network Provider, you will be required to pay the applicable copayment amount directly to the provider, and the In-Network Provider will file a claim with Mutual of Omaha on your behalf.

OUT-OF NETWORK PROVIDERS

If you choose to receive covered Dental services from an Out-of-Network Provider, you will be required to pay the full amount of charges for the services, and may then submit a claim to Mutual of Omaha for reimbursement, subject to applicable deductible, copayment and benefit limitations for Out-of-Network Provider services under the Dental Plan.

COVERED SERVICES

Covered Services are categorized as Type A Covered Services, Type B Covered Services and Type C Covered Services. A schedule of Covered Services is set forth on Appendix B, and is subject to change from year-to-year.

Unused annual benefit allowances for Covered Services may not be carried over into the following year.

DEDUCTIBLE

Benefits for Covered Services are subject to payment of a deductible, as follows:

Covered Service	In-Network Deductible	Out-of-Network Deductible
Type A Covered Services	Waived	Waived
Type B and C Covered Services	$25 for Individual $75 for Family	$75 Individual $225 Family
Orthodontia Covered Services	Waived	Waived

COPAYMENT

Benefits for Covered Services are payable at the following percentages, up to the Maximum Benefit for each Plan Year, and any remaining balance is a copayment that you are responsible for:

Covered Service	In-Network Payment	Out-of-Network Payment
Type A Covered Services	100%	100%
Type B Covered Services	90%	80%
Type C Covered Services	60%	50%
Orthodontia Covered Services	60%	50%

MAXIMUM PLAN YEAR BENEFIT

Benefits payable for each covered person under the Dental Plan are subject to a Maximum Plan Year Benefit of $1,750. This Maximum Plan Year Benefit applies to Covered Services from In-Network Providers and from Out-of-Network Providers in each Plan Year.

MAXIMUM LIFETIME ORTHODONTIA BENEFIT

In addition to the Maximum Plan Year Benefit, Orthodontia benefits payable for each covered person under the Dental Plan are subject to a Maximum Lifetime Orthodontia Benefit of $2,000. This Maximum Lifetime Orthodontia Benefit applies to Covered Services for Orthodontia from In-Network Providers and from Out-of-Network Providers.

PREDETERMINATION OF BENEFITS

Mutual of Omaha will provide you with a predetermination of your benefits for Covered Services upon request. Your dentist can submit a predetermination request on your behalf by completing a standard dental claim form and submitting it to:

Mutual of Omaha Insurance Company
P.O. Box 211472
Eagan, MN 55121

EXCLUDED SERVICES

Dental services that are not listed under Covered Services are ineligible for coverage under the Dental Plan. The following are among excluded services:

- Services that are considered experimental or an investigational device, treatment or procedure;
- Services that are not considered medically necessary, provided for patient convenience, or provided solely to relieve mental anxiety, unless specifically provided in Appendix B;
- Services for which benefits are payable under any other group health or dental plan maintained or sponsored by the Company;
- Services related to tests and laboratory exams, bacteriologic studies, caries susceptibility tests, pulp vitality tests, oral pathology laboratory, oral hygiene instruction, education or training, histopathologic examinations, diagnostic casts and photographs, the diagnosis or treatment of congenital malformations, magnetic resonance imaging and gnathological procedures, services, supplies or procedures related to orthognathic surgery, osteoplasties, osteotomies, LeFort procedures, maxillofacial prosthetics, vestibuloplasties, stomatoplasties, and any procedures related to the diagnosis or treatment of jaw fractures;
- Services related to orthodontic treatment, including diagnostic procedures;
- Services related to cosmetic or reconstructive procedures;
- Services related to restorations, devices, appliances or dentures to change vertical dimension, to alter occlusion or to replace tooth structure lost through attrition, erosion or abrasion including occlusal adjustment or equilibration;
- Services related to the replacement of lost dentures or the replacement of lost or broken appliances;
- Services related to athletic mouth guards or any procedure related to such appliance, except as specifically provided in Appendix B as an orthodontic or Temporomandibular Disorder (TMD) procedure;
- Services related to precision attachments, connector bars, coping materials, overdentures, unilateral partial dentures and stress breakers;
- Services related to drugs and medications whether or not they require a written prescription, or for analgesics or euphoric drugs, except as specifically provided in Appendix B;
- Services related to cast restorations, full or partial dentures and fixed bridgework when the final impressions were taken before the date coverage began under the Dental Plan or after coverage under the Dental Plan ends;
- Services customarily performed in association with a more comprehensive dental procedure, including local anesthesia, pulp capping (direct or indirect), insulating/cementing bases, periodontal splinting (permanent or provisional), temporary crowns, bridges, and dentures; or any minor associated gingival involvement when performed in conjunction with a cast restoration or fixed bridgework;
- Services related to any endodontic, periodontic, crown, bridge abutment or appliance performed on teeth with a guarded, questionable or poor prognosis;

- Services related to duplication of treatments, procedures or supplies, including when a covered person transfers from the care of one provider to the care of another provider;
- Services that arise out of or in the course of employment for any employer or that the covered person is paid benefits under any workers' compensation or occupational disease law, or receives any settlement from a worker's compensation carrier;
- Services for which the covered person is not liable for payment;
- Services provided or paid for by a state or federal government or its agencies;
- Services resulting from an intentionally self-inflicted injury;
- Services resulting from the covered person's voluntary participation in a riot or in the commission of a felony;
- Services resulting from an act of declared or undeclared war or armed aggression;
- Services incurred while the covered person is on active duty or training in the Armed Forces, National Guard, Reserves or an auxiliary unit of any state or country or which any governmental body or its agencies are liable; and
- Services provided by a person who is a member of the covered person's (Spouse; or a child, brother, sister or parent).

VII. WHEN DENTAL COVERAGE ENDS

Dental coverage will end on the last day of the month in which the *earliest* of the following events occurs:

- You terminate employment with the Company or otherwise cease to meet the eligibility requirements;
- With respect to your Spouse or Children (including Incapacitated Children), they cease to meet the requirements of an Eligible Dependent;
- You begin active duty in the Armed Forces, National Guard, or Reserves of any state or country (except for temporary active duty of 31 days or less); or
- The Company terminates the Dental Plan.

VIII. LEAVE OF ABSENCE

If your Dental coverage ends because you are no longer an active full-time employee due to a Company approved leave of absence, coverage may be reinstated effective upon returning to full-time employment status within 90 days after coverage had ended.

If your Dental coverage ends because you are on active duty in the Armed Forces, National Guard, or Reserves of any state or country (except for temporary active duty of 31 days or less), coverage may be reinstated effective upon returning to full-time employment status within 31 days after discharge from such active duty.

IX. COBRA CONTINUATION COVERAGE

If your coverage or your Eligible Dependents' coverage under the Dental Plan ends due to a "**Qualifying Event**," you or your Eligible Dependents may elect to continue coverage as provided under the Consolidated Omnibus Budget Reconciliation Act ("**COBRA**").

Please refer to the Additional Information SPD for more information on Qualifying Events and the terms and conditions of COBRA coverage.

X. FILING A CLAIM

If Covered Services are provided by an In-Network Provider, the provider will bill Mutual of Omaha directly and will notify you of any required copayment or balance, which you are responsible for paying to the provider.

If Covered Services are provided by an Out-of-Network Provider, you are responsible for paying the amount due to the provider. You may then file a claim for reimbursement of the Covered Services, to the extent provided under the Dental Plan.

A claim form with instructions for filing a claim for reimbursement of Covered Services provided by an Out-of-Network Provider is available at www.MutualofOmaha.com/dental or by calling Mutual of Omaha at (800) 927-9197. Claim forms are also available on the ADP MyLife Advisors resource website for the Health and Welfare Benefit Plan at **https://mylife-ts.adp.com** or by calling ADP MyLife Advisors at (855) 547-8508. For assistance with filing a claim, contact Hope Gas Benefits:

Hope Gas, Inc. Benefits
781 Chestnut Ridge Road, Suite 100
Morgantown, WV 26505
(304) 566-2959
Samantha.j.baxter-nard@hopegas.com

XI. COORDINATION OF BENEFITS

If you or your Eligible Dependent have Dental coverage under another plan or plans, benefits under this Dental Plan and the other plan or plans will be coordinated under these coordination of benefits procedures (the "**COB Procedures**").

With respect to a claim for Covered Services for a person covered under this Dental Plan (a "**Claimant**"), the plan that is required to pay for Covered Services first under these COB Procedures is the "**Primary Plan**."

The plan or plans that are not the Primary Plan are a "**Secondary Plan**."

If this Dental Plan is the Secondary Plan, the sum of benefits paid for a Covered Service under the Primary Plan plus the amount paid under this Dental Plan will not exceed 100% of the expense for the Covered Service.

If the other dental plan (i) does not have rules for coordinating benefits with this Dental Plan, or (ii) has rules for coordinating benefits that differ with these COB Procedures, then the other dental plan is the Primary Plan.

If the other dental plan has rules for coordinating benefits that are compatible with these COB Procedures, then the following order of benefit determination rules will determine the Primary Plan:

1. (a) If a plan covers the Claimant as an employee, retiree, member, subscriber, or nondependent, then it will be the Primary Plan.

(b) Notwithstanding the rule in (1)(a) above, if (i) one plan covers the Claimant as a laid-off or retired employee (or a dependent of such person); and (ii) the other plan includes a coordination of benefits rule for laid-off or retired employees (or is required to have this rule under applicable state law), then the plan that covers the Claimant as other than a laid-off or retired employee (or a dependent of such person) will be the Primary Plan.

2. (a) If the Claimant is a dependent child whose parents: (i) are not divorced or separated; or (ii) are divorced or separated, but the parents share joint custody pursuant to a court decree that does not designate a parent to be responsible for the child's dental coverage, then the plan of the parent whose birthday anniversary is earlier in the calendar year will be the Primary Plan; provided, that if both parents have the same birthday, then the Primary Plan will be determined under the rule in (4) below.

(b) Notwithstanding the rule in (2)(a) above, if the other plan does not include this coordination of benefits rule based on the parents' birthdays, but instead has a rule based on the gender of the parent, then the other plan's Coordination of Benefits rule will determine the Primary Plan.

3. If the Claimant is a dependent child whose parents are divorced or separated (except when sharing joint custody):

(a) The plan that covers the child as a dependent of a parent who by court decree must provide dental coverage will be the Primary Plan, subject to the plan having actual knowledge of the court decree.

(b) If there is no court decree requiring a parent to provide dental coverage to the dependent child, or if the plan covering the parent has no knowledge of such court decree, (i) the plan of the parent who has custody of the child and has not remarried will be the Primary Plan, and (ii) the plan of the parent who has custody of the child and has remarried will be the Primary Plan, the plan of the stepparent will pay second as a Secondary Plan and the plan of the parent without custody will pay third as a Secondary Plan.

4. If none of the above rules (1) through (3) are applicable, then the plan that has covered the Claimant for the longer period of time will be the Primary Plan.

XII. REIMBURSEMENT RIGHTS AND SUBROGATION RIGHTS

This section applies if you or your Eligible Dependent suffer a loss that is otherwise payable under the Dental Plan but is the result of an act or omission of a third party.

If you or your Eligible Dependent has an injury or sickness caused by another person or organization's act or omission, the Dental Plan will pay benefits for Covered Services, subject to Mutual of Omaha's Reimbursement Rights and Subrogation Rights and on the condition that you or your Eligible Dependent (or the legal representative of you or your Eligible Dependent): (i) will not take any action that would prejudice Mutual of Omaha's Reimbursement Rights or Subrogation Rights; and (ii) will cooperate in doing what is reasonably necessary to assist Mutual of Omaha in enforcing its Reimbursement Rights or Subrogation Rights.

Mutual of Omaha's Reimbursement Rights or Subrogation Rights will not be limited or reduced because: (i) the recovery does not fully compensate you or your Eligible Dependent for all losses sustained or alleged, or (ii) the recovery is not described as being related to medical or dental costs or loss of income.

Mutual of Omaha may enforce its Reimbursement Rights or Subrogation Rights by filing a lien with the other person or organization, their insurer or another insurer, a court having jurisdiction in the matter or any other appropriate party.

The amount of Mutual of Omaha's reimbursement will not be reduced by legal fees or court costs incurred in seeking the recovery, unless they agree otherwise in writing.

Mutual of Omaha may elect to charge any reimbursement due to them pursuant to this section on Reimbursement Rights and Subrogation Rights against any future benefit payments for you or your Eligible Dependents under the Dental Plan.

XIII. CLAIMS PROCEDURES

Mutual of Omaha will provide notice of its decision within 48 days of the date a Dental claim is received. This time period may be extended twice by a period of 30 days if Mutual of Omaha both determines that such an extension is necessary due to matters beyond their control and notifies you of the circumstances requiring the extension of time and the date by which Mutual of Omaha expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days from receipt of such notice within which to provide the specified information. If you deliver the requested information within the time specified, a 30-day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Mutual of Omaha may decide your claim without that information.

If your claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the Plan will:

- State the specific reason(s) for the determination;
- Reference specific Plan provisions on which the determination is based;
- Describe additional material or information necessary to complete the claim and why such information is necessary;
- Describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to sue in federal court; and
- Disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

APPEAL PROCEDURES

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review of your appeal will be made not later than 60 days following receipt of the written request for review. If Mutual of Omaha determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 60 days (120 days in total). Mutual of Omaha will notify you in writing if an extension is needed.

If an extension is necessary due to your failure to submit the information necessary to make a determination on your appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 30 days from receipt of the notice to provide the specified information. If you deliver the requested information within the time specified, the 30-day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Mutual of Omaha may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by Mutual of Omaha and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, Mutual of Omaha will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your claim, Mutual of Omaha will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your claim on appeal is denied will contain the following information:

- The specific reason(s) for the determination;
- A reference to the specific Plan provisions on which the determination is based;
- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);
- A statement describing your right to bring a civil suit under federal law; and
- The statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

XIV. PLAN DOCUMENTS

The information in this Dental SPD has been prepared to describe the Dental Plan benefits under the Health and Welfare Benefit Plan that are available to you and your Eligible Dependents. If there is a conflict between this information and the official documents and contracts that govern the Dental Plan and the Health and Welfare Benefit Plan, those official documents and contracts will govern.

XV. CHANGING OR TERMINATING THE DENTAL PLAN

Please see the “Changing or Terminating the Plans” section of the Additional Information SPD for information on the Company’s ability to change or terminate the Dental Plan.

XVI. OTHER RIGHTS

The Company, for itself as Plan Administrator and on behalf of the Plan, is entitled to legal and equitable relief to enforce its right to recover any benefit overpayments caused by your receipt of deductible sources of income from a third party to the extent permitted under applicable federal or state laws and regulations. This right of recovery is enforceable even if the amount you receive from the third party is less than the actual loss suffered by you, but the recovery will not exceed the benefits paid to you under the Plan. The Plan Administrator and the Plan have an equitable lien over such sources of income until any benefit overpayments have been recovered in full.

APPENDIX A

DENTAL COVERAGE PREMIUMS

As of January 1, 2026, the annual Dental coverage premium amounts are as follows:

Coverage Level	Employee Premium (Monthly)	Company Premium (Monthly)	Total Monthly Premium
Employee only	$10.83	$15.27	$26.10
Employee and Spouse	$21.67	$32.27	$53.94
Employee and Eligible Dependent Children (including Incapacitated Children)	$26.00	$38.30	$64.30
Employee and Eligible Dependents (Spouse + Eligible Dependent Children)	$39.00	$60.22	$99.22

***Employee contribution rates for dental insurance will be professionally assessed and determined and will not increase by more than the same percentage incurred by the company. The increases will also be subject to the following yearly cap of 13% for 2027. At least thirty (30) days prior to open enrollment the company shall provide the union with full detailed documentation supporting such increase for benefit (medical, dental, vision) premiums.

APPENDIX B
COVERED SERVICES

As of January 1, 2026, Covered Services for In-Network Providers and Out-of-Network Providers are as follows:

Type A Covered Services	Benefit
Examination/Evaluations	2 service in a 12-month period.
Bitewing X-rays	4 x-rays in a 12 month period.
Full Mouth Series or Panoramic X-rays	1 service in a 36-month period
Periapical or Occlusal X-rays	The submission of multiple X-rays taken on the same date of service will be covered up to the maximum allowed for Full Mouth Series of X-rays.
Fluoride Treatment	1 service in a 12 month period for Dependent children up to age 14.
Cleaning (Prophylaxis)	2 services in a 12-month period.
Sealants	1 service per occlusal surface of first and second permanent molars without existing fillings in 60-month period for Eligible Dependent Children up to age 19.
Space Maintainers, including recementations	Benefits are payable for initial placement and any recommendation for Eligible Dependent Children up to age 19.
Palliative Treatment	Benefits are payable for treatment of minor dental pain.
Brush Biopsy / Cancer Screen	2 services in a 12 month period.

Type B Covered Services	Benefit
Periodontal Maintenance	2 services in a 12 month period in addition to routine cleanings. Benefits are payable only when this procedure follows active periodontal treatment.
Bruxism Appliance	1 appliance in any 36 month period. Includes all adjustments.
Fillings	Benefits are payable for amalgam (silver) and composite/resin (white) fillings. Composite fillings on molars are limited to the amount otherwise payable for an amalgam filling. Replacement of fillings allowed once in a 12 month period.
Stainless Steel and Other Prefabricated Crowns	Benefits are payable 1 per tooth per lifetime up to age 16.
Simple Extractions	Benefits are payable for simple extractions of erupted teeth.
Surgical Extractions	Benefits are payable for the extraction of teeth requiring a cutting procedure.
Endodontics	Benefits payable for services such as pulpal therapy and root canal therapy. Retreatment of root canal payable once in a lifetime and only after 12 months have passed since original root canal was completed.

Type B Covered Services (continued)	Benefit
Periodontics – Surgical	Benefits are payable for surgical treatment of gum and supporting bone disease. Services are limited to one service per area of the mouth in a 36 month period.
Periodontics – Non-Surgical	Benefits are payable for non-surgical services such as scaling and root planning. Services are limited to one service per area of the mouth in a 24 month period.
Repair of Full or Partial Removable Dentures	Benefits are payable if the service is performed more than 6 months after initial denture placement. Benefits are payable once in any 24 month period. Benefits include the addition of teeth to a denture.
Adjustments to Full or Partial Removable Dentures	Benefits are payable if the service is performed more than 6 months since initial insertion of the denture. Payable once in 12 months thereafter.
Tissue Conditioning, Rebasing or Relining of Full or Partial Removable Dentures	Benefits are payable if the service is performed more than 6 months after any previous adjustment, tissue conditioning, rebasing or relining. Payable once in 24 months thereafter.
Repair and Recementation of Bridgework	Benefits are payable if the service is performed more than 6 months after initial bridge placement. Payable once in 12 months thereafter.
Repair and Recementation of Cast Crowns, Inlays, On lays, and Labial Veneers	Benefits are payable if the service is performed more than 6 months after initial restoration placement. Payable once in 12 months thereafter.
Oral surgery	Benefits are payable for oral surgery, including x-rays, pre- and postoperative care, and surgical extractions. This benefit does not include TMD surgery.
General Anesthesia or Intravenous (I.V.) Sedation	Benefits are payable when service is provided with a covered surgical procedure.

Type C Covered Services	Benefit
Full or Partial Removable Dentures	Benefits are payable for final dentures.
Replacement of Full or Partial Removable Dentures	Benefits are payable if the existing denture is more than 5 years old or significant structural changes occurred within the mouth due to extractions or other oral surgery.
Bridgework	Benefits are payable for the replacement of lost, extracted, or congenitally missing teeth. Benefits are payable for Insured Persons aged 16 and older.
Replacement of Bridgework	Benefits payable if the existing bridgework is more than 5 years old or significant structural changes occurred within the mouth due to extractions or other oral surgery.

Type C Covered Services (continued)	Benefit
Cast Crowns, Inlays, On lays, and Labial Veneers	Benefits for veneered molar crowns are equal to the amount otherwise payable for cast metal crowns. Benefits are payable for damage due to decay or tooth fracture, but only if the tooth cannot be restored with standard filling material. Benefits are payable for covered persons age 16 and older.
Replacement of Cast Crowns, Inlays, On lays, and Labial Veneers	Benefits are payable if the existing crown, inlay, on lay or veneer is more than 5 years old and cannot be repaired.
Implants	Once per tooth per lifetime.
Temporomandibular Disorder (TMD) Services	Benefits are payable for services such as x-rays, cast restorations, and orthotic appliances.

Orthodontic Covered Services	Benefit
Dependent Child and Adult	Benefits are payable for orthodontic services including x-rays, case work up, consultation, appliances, and post-treatment retention. Orthodontic treatment is deemed to have begun at the time of banding and/or when other orthodontic appliances are initially placed in connection with a current course of treatment.
Harmful Habit Appliance	Benefits are payable for Eligible Dependent Children up to age 14. Includes all adjustments.