



2024 Dental Coverage Summary Plan Description



Dental Coverage

Bimbo Bakeries USA (BBU) and Bimbo QSR (the “Company”) offers two Dental Plan options administered by Delta Dental that are available to you and your eligible dependents. Both options cover preventive dental care — including exams, cleanings and X-rays — at 100% of allowed amount, with no additional cost to you when you use in-network providers. For all other services, you are responsible for payment of the deductible and applicable coinsurance, as described in the Summary of Benefits on **page 3**.

You can choose between two options: Standard and High. However, you and each of your dependents under the Dental Plan must choose the same option. Your choice of dependents under the Dental Plan can be different from your choice of dependents covered under other benefit plans. Please refer to the Administrative Summary Plan Description (SPD) for information on eligibility, enrollment, cost of coverage, and claim filing and appeals for the Dental Plan.

Deductibles and Annual Maximums **Delta Dental Networks**

Regardless of which option you select, for certain services your dental benefits are subject to an annual deductible. That means that before the Dental Plan pays any dental benefits for services provided in that calendar year, you must have paid for services in that year up to the deductible limit. After the deductible has been met, the Dental Plan pays a specified percentage of the cost of each covered service. The percentage, which is specified in the Summary of Benefits on **page 3**, depends on which option you choose, your level of coverage and the service being provided. The amount paid by the Dental Plan is also subject to annual and lifetime maximums, which are also listed in the Summary of Benefits.

How the Plan Reimburses Orthodontia Treatment

For comprehensive orthodontia treatment, the Plan reimburses care in two equal installments if over \$500. The first installment is paid when the braces are first put on, and the second is paid one year later, as long as the dependent is still eligible and enrolled. The second payment is paid based on the plan maximum at the time of the (second) payment. If the service is less than \$500, it is paid in one lump sum.

The Standard and High options include work-in-progress for orthodontia. The orthodontist will need to submit a claim to Delta Dental with all the treatment details, including the banding date, treatment length and amount covered by any prior insurance. Delta Dental will pro-rate the payment based on the remaining treatment less the amount paid by prior insurance.

With both the Standard and High options, you can choose from Delta Dental’s two provider networks. Delta Dental PPO network dentists generally offer the lowest contracted rates and greatest cost savings. The Delta Dental Premier network is broader than the PPO network, so you’ll have greater choice in providers; however, your out-of-pocket costs may be higher than if you had received care from a PPO network dentist.

By selecting a participating dentist, you limit your out-of-pocket costs. Your out-of-pocket payment is likely to be the lowest if you go to a Delta Dental PPO dentist, higher if you go to a Delta Dental Premier dentist and the highest if you go to a nonparticipating dentist.

When you use a participating dentist, your charges are based on Delta Dental’s applicable Maximum Plan Allowance or the dentist’s actual charge, whichever is less (the Allowed Amount). By agreement, a participating dentist cannot bill you more than the Allowed Amount for covered services.

Administrative SPD

The Dental Plan benefits described in this SPD are offered under the Bimbo Bakeries USA Health & Welfare Plan. The Plan provides benefits in accordance with applicable federal laws. Additional information, including administrative and legal information about the Dental Plan, is described separately in the Administrative SPD. This SPD and the Administrative SPD should be read together.

Summary of Benefits

The following coverage levels apply to both Standard and High options, in-network or out-of-network.

Diagnostic (deductible waived and exempt from maximum) <ul style="list-style-type: none"> Routine exams (twice per calendar year) Bitewing X-rays (twice per calendar year) Full mouth X-rays (once every three years) Palliative care Panoramic X-rays (once every three years) 	Plan pays 100% *	
Preventive (deductible waived and exempt from maximum) <ul style="list-style-type: none"> Prophylaxis cleaning (twice per calendar year)** Fluoride treatments (twice per calendar year to age 19) Sealants (limited to posterior teeth for a person less than 19; one treatment per tooth every 3 years) Space maintainers (to age 19) One extra preventive cleaning for women anytime during pregnancy 	Plan pays 100% *	
Basic Restorative <ul style="list-style-type: none"> Fillings (amalgam “silver” and “white” composite) 	Plan pays 80% *	
Major Restorative <ul style="list-style-type: none"> Single crowns, inlays, onlays 	Plan pays 50% *	
Oral Surgery <ul style="list-style-type: none"> Extraction and other oral surgery procedures, including pre- and post-operative care 	Plan pays 80% *	
Endodontics <ul style="list-style-type: none"> Root canal, pulpal therapy 	Plan pays 80% *	
Periodontics <ul style="list-style-type: none"> Treatment of the gums and supporting structures of the teeth Periodontal cleanings (twice per calendar year)** 	Plan pays 80% *	
Prosthodontics <ul style="list-style-type: none"> Procedures for replacement of missing teeth by construction or repair of bridges and partial or complete dentures Implants 	Plan pays 50% *	
Dependent Orthodontics (up to age 19) <ul style="list-style-type: none"> Straightening of teeth 	Plan pays 50% *	
Denture Repair and Relining	Plan pays 80% *	
Temporomandibular Joint Dysfunction (TMJ)	Plan pays 50% *	
Orthodontia Lifetime Maximum (up to age 19)	Standard: Plan pays \$1,500 per person	High: Plan pays \$2,500 per person
TMJ Lifetime Maximum	Plan pays \$1,000 per person	

Note: Coinsurance percentages are based on Delta Dental’s Maximum Plan Allowance or the dentist’s actual charges, whichever is less.

* For **Delta Dental PPO** dentists, percentages are based on the PPO Allowed Amount, which is the lesser of the dentist’s submitted fee or the PPO Maximum Plan Allowance. For **Delta Dental Premier** dentists and nonparticipating dentists, percentages are based on the Premier Allowed Amount, which is the lesser of the dentist’s submitted fee or the Premier Maximum Plan Allowance.

Certain combined limits apply each calendar year and members with certain conditions including diabetes, high-risk cardiovascular disease, dialysis, cancer-related chemotherapy and others are eligible for up to four cleanings per calendar year. Contact Delta Dental at **1-800-471-5612 for more information.

Deductibles and Maximums

Standard		
	In-Network	Out-of-Network
Deductible Individual Family	\$75 \$150	\$100 \$200
Annual Maximum (applies to basic and major services only)	Plan pays \$1,000 per person	
Orthodontia (lifetime maximum benefit, for children up to age 19)	Plan pays \$1,500 per person	
TMJ (lifetime maximum)	Plan pays \$1,000 per person	

High		
	In-Network	Out-of-Network
Deductible Individual Family	\$100 \$200	\$125 \$225
Annual Maximum (applies to basic and major services only)	Plan pays \$2,000 per person	
Orthodontia (lifetime maximum benefit, for children up to age 19)	Plan pays \$2,500 per person	
TMJ (lifetime maximum)	Plan pays \$1,000 per person	

Exclusions

The Dental Plan covers a wide variety of dental care expenses, but there are some services for which the Dental Plan does not provide benefits. It is important for you to know what these services are before you visit your dentist. The following exclusions apply to both Dental Plan options.

The Dental Plan does not provide benefits for:

1. Treatment or materials that are benefits to an enrollee under Medicare or Medicaid unless this exclusion is prohibited by law.
2. Treatment or materials to correct congenital or developmental malformations (including treatment of enamel hypoplasia) except for newborn children eligible at birth, so long as such eligible children continue to be enrolled. When services are not excluded under this provision, congenital defects or anomalies specifically include cleft lip or cleft palate, and other limitations and exclusions of this section shall specifically apply.
3. Treatment that increases the vertical dimension of an occlusion, or replaces tooth structure lost by attrition, erosion or otherwise, unless it is part of a treatment dentally necessary due to accident or injury.
4. Treatment or materials primarily for cosmetic purposes, including but not limited to treatment of fluorosis (a type of discoloration of the teeth) and porcelain or other veneers not for restorative purposes, except as part of a treatment dentally necessary due to accident or injury. If services are not excluded as to particular teeth under this provision, cosmetic treatment of teeth adjacent to or near the affected teeth is excluded.
5. Treatment or materials for which the enrollee would have no legal obligation to pay.
6. Services provided or materials furnished prior to the effective eligibility date of an enrollee under this Dental Plan, unless the treatment was a year in duration and completed after the enrollee became eligible if no other limitations shall apply.
7. Periodontal splinting, equilibration, gnathological recordings and associated treatment, and extra-oral grafts.
8. Preventive plaque control programs, including oral hygiene instruction programs.
9. Myofunctional therapy, unless covered by the exception in Item 2 on this page.
10. Prescription drugs including topically applied medication for treatment of periodontal disease, premedication, analgesias, separate charges for local anesthetics and general anesthesia except as a covered benefit in conjunction with a covered oral surgery procedure.
11. Experimental procedures that have not been accepted by the American Dental Association.
12. Services provided or material furnished after the termination date of coverage for which premium has been paid, as applicable to individual enrollees, except this shall not apply to services commenced while the Dental Plan was in effect or the enrollee was eligible.
13. Charges for hospitalization or any other surgical treatment facility, including hospital visits.
14. Dental practice administrative services including but not limited to preparation of claims, any nontreatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs and masks, or relaxation techniques such as music.
15. Replacement of existing restorations for any purpose other than restoring active carious lesions or demonstrable breakdown of the restoration.

This SPD outlines provisions of the Company Dental Plan as of January 1, 2024. The Company reserves the right to change, amend, suspend or terminate any or all of the benefits under this Dental Plan, in whole or in part, at any time and for any reason, at its sole discretion.

Note that by adopting and maintaining these benefits, the Company has not entered into an employment contract with any associate. Nothing in the legal plan documents or in the SPDs gives any associate the right to be employed by the Company or to interfere with the Company's right to discharge any associate at any time.