DELTA DENTAL®

Premiums
Single: $0.00
Employee + Spouse: $27.17
Employee + Child(ren): $31.60
Family: $57.84

Delta Dental of Iowa

Employee Summary of Covered Services and Benefits

Washington County

Deductibles, Maximums & Eligibility	Delta Dental PPO℠	Delta Dental Premier® / Non Par
- Individual Deductible	$25	$50
- Family Deductible	$75	$150
- Deductible applies to Check-Ups and Teeth Cleaning?	No	No
- Benefit Period Maximum	$1,000	$1,000
- Eligible children to age	26	26
- Full-time (unmarried) students eligible to age	99	99
Benefits		
Check-Ups and Teeth Cleaning (Diagnostic and Preventive Services)	0%	0%
- Dental Cleaning	*2 in a benefit period aggregate with perio maintenance therapy*	
- Oral Evaluations	*2 in a benefit period*	
- Fluoride Applications	*1 every 12 months to age 19*	
- X-Rays	*Bitewings - 1 every 12 months; Full mouth - 1 every 5 years*	
- Sealant Applications	*1 in a lifetime per permanent 1st and 2nd molars to age 15*	
- Space Maintainers	*To age 15*	
Cavity Repair and Tooth Extractions (Routine and Restorative Services)	10%	20%
- Emergency Treatment		
- General Anesthesia/Sedation		
- Restoration of Decayed or Fractured Teeth		
- Limited Occlusal Adjustments		
- Routine Oral Surgery		
- Posterior Composites w/ Alternate Processing		
Root Canals (Endodontic Services)	50%	50%
- Apicoectomy		
- Direct Pulp Cap		
- Pulpotomy		
- Retrograde Fillings		
- Root Canal Therapy		
Gum and Bone Diseases (Periodontal Services)	50%	50%
- Conservative Procedures (Non-surgical)	*1 every 24 months per quadrant*	
- Complex Procedures (Surgical)	*1 every 36 months per quadrant*	
- Periodontal Maintenance Therapy	2 in a benefit period aggregate with dental cleaning	
High Cost Restorations (Cast Restorations)	50%	50%
- Cast Restorations		
- Crowns	*1 every 5 years*	
- Inlays	*1 every 5 years*	
- Onlays	*1 every 5 years*	
- Post and Cores		
- Recementing Crowns/Inlays/Onlays		
Dentures and Bridges (Prosthetic Services)	50%	50%
- Bridges	*1 every 5 years*	
- Dentures	*1 every 5 years*	
- Repairs and Adjustments		
- Recementing of Bridges		
- Implants Not Covered		
Straighter Teeth (Orthodontics)	Not Covered	Not Covered
Additional Options		
-Annual Maximum Carryover - To GoSM	*Included*	*Included*

** This dental plan includes the Annual Maximum Carryover – To Go℠ for carryover of unused Benefit Period Maximums to the next benefit contract year. Please refer to your dental benefits document for details.

The percentage shown is the coinsurance amount that is the responsibility of the Covered Person.

This is a general description of coverage. It is not a statement of your contract. Actual coverage is subject to terms and conditions specified in the benefits document itself and enrollment regulations in force when the benefits become effective. Certain exclusions and limitations apply. Please refer to your dental benefits document for details.

Plan Year 2016