



Delta Dental of Iowa

Employee Summary of Covered Services and Benefits

Scott County - Buy Up

Deductibles, Maximums & Eligibility	Delta Dental PPO SM	Delta Dental Premier [®] / Non Par
- Individual Deductible	\$0	\$25
- Family Deductible	\$0	\$75
- Deductible applies to Check-Ups and Teeth Cleaning?	No	No
- Benefit Period Maximum	\$1,500	\$1,500
- Eligible children to age	26	26
- Full-time (unmarried) students eligible to age	99	99
- Does Individual Deductible apply to Orthodontics?	Yes	Yes
- Orthodontic lifetime maximum	\$1,500	\$1,500
- Orthodontics: Eligible children to age	26	26
- Orthodontics: Full-time students eligible to age	99	99
- Adult Orthodontics	Yes	Yes
Benefits		
Check-Ups and Teeth Cleaning	0%	0%
(Diagnostic and Preventive Services)		
- Dental Cleaning		
- Oral Evaluations		
- Fluoride Applications		
- X-Rays		
- Sealant Applications		
- Space Maintainers		
Cavity Repair and Tooth Extractions	10%	20%
(Routine and Restorative Services)		
- Emergency Treatment		
- General Anesthesia/Sedation		
- Restoration of Decayed or Fractured Teeth		
- Limited Occlusal Adjustments		
- Routine Oral Surgery		
- Consultations		
- Posterior Composites w/o Alternate Processing		
Root Canals (Endodontic Services)	10%	20%
- Apicoectomy		
- Direct Pulp Cap		
- Pulpotomy		
- Retrograde Fillings		
- Root Canal Therapy		
Gum and Bone Diseases (Periodontal Services)	10%	20%
- Conservative Procedures (Non-surgical)		
- Complex Procedures (Surgical)		
- Periodontal Maintenance Therapy		
High Cost Restorations (Cast Restorations)	20%	20%
- Cast Restorations		
- Crowns		
- Inlays		
- Onlays		
- Post and Cores		
- Recementing Crowns/Inlays/Onlays		
Dentures and Bridges (Prosthetic Services)	50%	50%
- Bridges		
- Dentures		
- Repairs and Adjustments		
- Recementing of Bridges		
- Implants		
Straighter Teeth (Orthodontics)	50%	50%
Additional Options		
-Enhanced Benefits Program	Included	Included
-Annual Maximum Carryover - To GoSM	Included	Included

This dental plan includes the Enhanced Benefits Program (EBP) which allows additional benefits for Covered Person(s) with designated dental or medical conditions. Please refer to your dental benefits document for details.

** This dental plan includes the Annual Maximum Carryover – To GoSM 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.