

PLAN 2

SUMMARY OF COVERAGE

Deductible

Individual
Family

\$15*
\$45*

Delta Dental Premier®/
Out-of-Network Dentist

\$25*
\$75*

Annual Period Maximum
per person per calendar year

\$1,500

Annual Maximum Carry Over - To Go^{SM}**

Included

Enhanced Benefits Program

Included

BENEFIT CATEGORIES

Coinsurance paid by member

Diagnostic & Preventive Services
(check-ups, teeth cleaning, x-rays)

0%

Routine & Restorative Services
(cavity repair, tooth extractions, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery)

10%

20%

Endodontic Services
(root canals and therapy, apicoectomy, direct pulp cap, retrograde fillings)

20%

Periodontal Services
conservative procedures (nonsurgical) and maintenance therapy
complex procedures (surgical)

20%

Not Covered

High Cost Restorations
(cast restorations - crowns, inlays, onlays, posts, cores)

20%

Prosthetics
(bridges, dentures, implants)

Not Covered

Corrective Orthodontia Benefit & Lifetime Maximum

Not Covered

Monthly Rates

Single

\$37

Employee / Child(ren)

\$80

Family

\$109

Percentages shown are what the member pays. Eligible children up to age 26. Full-time (unmarried) students eligible to age 99.

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 or Delta Dental of Iowa's website, www.deltadentalia.com for details.

*Deductible is waived for all diagnostic and preventive care.

**Annual Maximum Carry Over - To GoSM allows members to carry over a portion of their unused Annual Benefit Maximum to the next benefit year.

The information on this page summarizes your benefits and payment obligations. This is a general description of your benefits. Please see your benefits document for a full description of coverage.