PLAN 3

SUMMARY OF COVERAGE	Delta Dental PPO™ Dentist	Delta Dental Premier®/ Out-of-Network Dentist
Deductible		
Individual	$15*	$25*
Family	N/A	N/A
Annual Period Maximum per person per calendar year	$1,000	
Annual Maximum Carry Over - To Go℠**	Included	
Enhanced Benefits Program	Included	

BENEFIT CATEGORIES	Coinsurance paid by member	
Diagnostic & Preventive Services (check-ups, teeth cleaning, x-rays)	10%	20%
Routine & Restorative Services (cavity repair, tooth extractions, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery)	20%	
Endodontic Services (root canals and therapy, apicoectomy, direct pulp cap, retrograde fillings)	20%	
Periodontal Services		
conservative procedures (nonsurgical) and maintenance therapy	20%	
complex procedures (surgical)	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	$29
Employee / Child(ren)	$62
Family	$86

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 Go℠ 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.

Iowa Bankers Benefit Plan Customer Service 1-800-258-1415