# Delta Dental of Iowa

## Employee Summary of Covered Services and Benefits

### University of Iowa

### Deductibles, Maximums & Eligibility

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Delta Dental PPO℠</th>
<th>Delta Dental Premier℠ / Non Par</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Deductible</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Deductible applies to Check-Ups and Teeth Cleaning?</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Benefit Period Maximum</td>
<td>$2,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>Eligible children to age</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>Full-time (unmarried) students eligible to age</td>
<td>99</td>
<td>99</td>
</tr>
<tr>
<td>Orthodontic annual deductible</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td>Included in Benefit Period Maximum?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Orthodontics: Eligible children to age</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>Orthodontics: Full-time students eligible to age</td>
<td>99</td>
<td>99</td>
</tr>
<tr>
<td>Adult Orthodontics</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### Benefits

#### Check-Ups and Teeth Cleaning

**Number of Services per Benefit Period:**

- Dental Cleaning: 2
- Oral Evaluations: 2
- 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
- Periodontal Maintenance Therapy: 2 in a benefit period aggregate with dental cleaning

**Percentage:**

- 0%

#### Cavity Repair and Tooth Extractions

**Percentage:**

- 0%

#### Root Canals (Endodontic Services)

- Apicoectomy: 10%
- Direct Pulp Cap: 20%
- Pulpotomy: 10%
- Retrograde Fillings: 20%
- Root Canal Therapy: 10%

**Percentage:**

- 10%

#### Gum and Bone Diseases (Periodontal Services)

- Conservatory Procedures (Non-surgical): 10%
- Complex Procedures (Surgical): 20%

**Percentage:**

- 10%

#### High Cost Restorations (Cast Restorations)

- Cast Restorations: 10%
- Crowns: 20%
- Inlays: 20%
- Onlays: 20%
- Post and Cores: 20%
- Recementing Crowns/Inlays/Onlays: 20%

**Percentage:**

- 10%

#### Dentures and Bridges (Prosthetic Services)

- Bridges: 10%
- Dentures: 20%
- Repairs and Adjustments: 20%
- Recementing of Bridges: 20%

**Percentage:**

- 10%

#### Straighter Teeth (Orthodontics)

**Percentage:**

- 50%

### Additional Options

- CheckUp Plus™: Included
- Enhanced Benefits Program: Included
- Annual Maximum Carryover – To GoSM: Included

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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.

This dental plan includes CheckUp Plus™ which means Diagnostic and Preventive covered dental service costs do not apply towards the Covered Person’s deductible or benefit period maximum. 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.