



Delta Dental of Iowa
Summary of Covered Services and Benefits
Plan B, No Ortho

	PREMIER	NON-PAR
Deductible	\$25/\$75	\$50/\$150
Annual Maximum**	\$2,000	
Benefit Categories	Coinsurance Paid By Member	
Check-Ups and Teeth Cleaning * (Diagnostic and Preventive Services)		
1. Dental Cleaning	0%	20%
2. Oral Evaluation		
3. Fluoride Applications		
4. X-rays		
5. Sealant Applications		
6. Space Maintainers		
7. Maintenance Therapy		
Cavity Repair and Tooth Extractions (Routine and Restorative Services)	20%	40%
1. Emergency Treatment		
2. General Anesthesia/Sedation		
3. Restoration of Decayed or Fractured Teeth		
4. Limited Occlusal Adjustment		
5. Routine Oral Surgery		
Posterior Composites	50%	60%
Root Canals (Endodontic Services)	50%	60%
1. Apicoectomy		
2. Direct Pulp Cap		
3. Pulpotomy		
4. Retrograde Fillings		
5. Root Canal Therapy		
Gum and Bone Diseases (Periodontal Services)	50%	60%
1. Conservative Procedures		
2. Complex Procedures		
High Cost Restorations (Cast Restorations)	50%	60%
1. Cast Restorations		
a. Crowns		
b. Inlays		
c. Onlays		
d. Posts and Cores		
Dentures and Bridges (Prosthetics)		
1. Bridges	50%	60%
2. Dentures	50%	60%
3. Repairs and Adjustments	20%	40%

*Deductible for Benefit Category Check-ups and Teeth Cleaning will be waived for Delta Dental Premier dentists

** Combined Maximum for Premier and Non-Participating Providers

Annual Maximum Carryover - ToGoSM - see Benefit Certificate for details

The information on this page summarizes your benefits and payment obligations. For a detailed description of specific benefits and benefit limitations, see the IMPORTANT INFORMATION and BENEFITS sections of your certificate.