



Delta Dental of Iowa
Atlantic Bottling Company - Low Plan

Employee Summary of Covered Services and Benefits

| Deductibles, Maximums & Eligibility | Delta Dental PPO SM | Delta Dental Premier [®] / Non Par |
|---|--------------------------------|---|
| - Individual Deductible | \$25 | \$50 |
| - Family Deductible | \$75 | \$150 |
| - Deductible applies to Check-Ups and Teeth Cleaning? | No | No |
| - Benefit Period Maximum | \$1,000 | \$1,000 |
| - Eligible children to age | 26 | 26 |
| - Full-time (unmarried) students eligible to age | 99 | 99 |
| Benefits | | |
| Diagnostic and Preventive Services (Check-Ups and Teeth Cleaning) | 0% | 0% |
| - Dental Cleaning | | |
| - Oral Evaluations | | |
| - Fluoride Applications | | |
| - X-Rays | | |
| - Sealant Applications | | |
| - Space Maintainers | | |
| Routine and Restorative Services (Cavity Repair and Tooth Extractions) | 10% | 20% |
| - Emergency Treatment | | |
| - General Anesthesia/Sedation | | |
| - Restoration of Decayed or Fractured Teeth | | |
| - Limited Occlusal Adjustments | | |
| - Routine Oral Surgery | | |
| - Posterior Composites w/ Alternate Processing | | |
| Root Canals (Endodontic Services) | 20% | 20% |
| - Apicoectomy | | |
| - Direct Pulp Cap | | |
| - Pulpotomy | | |
| - Retrograde Fillings | | |
| - Root Canal Therapy | | |
| Gum and Bone Diseases (Periodontal Services) | 20% | 20% |
| - Conservative Procedures (Non-surgical) | | |
| - Complex Procedures (Surgical) | | |
| - Periodontal Maintenance Therapy | | |
| High Cost Restorations (Cast Restorations) | 50% | 50% |
| - 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 Not Covered | | |
| Straighter Teeth (Orthodontics) | Not Covered | Not Covered |
| Additional Options | | |
| -Annual Maximum Carryover - To Go SM | Included | Included |

The percentage shown is the coinsurance amount that is the responsibility of the Covered Person.

This dental plan includes the Annual Maximum Carryover – To GoSM for carryover of unused Benefit Period Maximum to the next benefit contract year.

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.