Delta Dental of Iowa

ITA Group, Inc. - High Plan

Employee Summary of Covered Services and Benefits

Deductibles, Maximums & Eligibility	Delta Dental PPO℠	Delta Dental Premier® / Non Par
- Individual Deductible	$25	$50
- Deductible applies to Check-Ups and Teeth Cleaning?	No	No
- Benefit Period Maximum	$1,500	$1,500
- Eligible children through age	25	25
- Full-time (unmarried) students eligible through age	99	99
- Does Individual Deductible apply to Orthodontics?	No	No
- Orthodontic lifetime maximum	$1,500	$1,500
- Orthodontics: Eligible children through age	18	18
- Orthodontics: Full-time students eligible through age	18	18
- Adult Orthodontics	No	No
Benefits		
Diagnostic and Preventive Services (Check-Ups and Teeth Cleaning)	0%	0%
- Dental Cleaning		
- Oral Evaluations		
- Fluoride Applications		
- X-Rays		
- Sealant Applications		
- Space Maintainers		
- Periodontal Maintenance Therapy *	50%	50%
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/o Alternate Processing		
Root Canals (Endodontic Services)	50%	50%
- Apicoectomy		
- Direct Pulp Cap		
- Pulpotomy		
- Retrograde Fillings		
- Root Canal Therapy		
Gum and Bone Diseases (Periodontal Services)	50%	50%
- Conservative Procedures (Non-surgical)		
- Complex Procedures (Surgical)		
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)	50%	50%
Additional Options		
-Annual Maximum Carryover - To Go℠	Included	Included

*** Deductible applies to Periodontal Maintenance Therapy.**

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