



Delta Dental of Iowa  
ACT Education Corp. - Enhanced Plan

Employee Summary of Covered Services and Benefits

| Deductibles, Maximums & Eligibility                                       |   | Delta Dental Premier® |                                                                |
|---------------------------------------------------------------------------|---|-----------------------|----------------------------------------------------------------|
| - Individual Deductible                                                   |   | \$25                  |                                                                |
| - Family Deductible                                                       |   | \$75                  |                                                                |
| - Deductible applies to Check-Ups and Teeth Cleaning?                     |   | No                    |                                                                |
| - Benefit Period Maximum                                                  |   | \$1,500               |                                                                |
| - Eligible children to age                                                |   | 26                    |                                                                |
| - Full-time (unmarried) students eligible to age                          |   | 26                    |                                                                |
| - Does Individual Deductible apply to Orthodontics?                       |   | No                    |                                                                |
| - Orthodontic lifetime maximum                                            |   | \$2,500               |                                                                |
| - Orthodontics: Eligible children to age                                  |   | 19                    |                                                                |
| - Orthodontics: Full-time students eligible to age                        |   | 19                    |                                                                |
| - Adult Orthodontics                                                      |   | No                    |                                                                |
| Benefits                                                                  |   |                       |                                                                |
| Diagnostic and Preventive Services<br>(Check-Ups and Teeth Cleaning)      |   | 0%                    |                                                                |
| - Dental Cleaning                                                         |   |                       | 2 in a benefit period aggregate with perio maintenance therapy |
| - Oral Evaluations                                                        |   |                       | 2 in a benefit period                                          |
| - Fluoride Applications                                                   |   |                       | 1 in a benefit period to age 18                                |
| - X-Rays                                                                  |   |                       | Full mouth - 1 every 3 years                                   |
| - Sealant Applications                                                    |   |                       | 1 in a lifetime per permanent 1st and 2nd molars to age 15     |
| - Space Maintainers                                                       |   |                       | To age 15                                                      |
| - X-Rays - (Occlusal, ExtraOral, Periapical)                              | * | 20%                   |                                                                |
| - Consultations                                                           | * | 20%                   | 2 in a benefit period aggregate with Oral Evaluations          |
| Routine and Restorative Services<br>(Cavity Repair and Tooth Extractions) |   | 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%                   |                                                                |
| - Apicoectomy                                                             |   |                       |                                                                |
| - Direct Pulp Cap                                                         |   |                       |                                                                |
| - Pulpotomy                                                               |   |                       |                                                                |
| - Retrograde Fillings                                                     |   |                       |                                                                |
| - Root Canal Therapy                                                      |   |                       |                                                                |
| Gum and Bone Diseases (Periodontal Services)                              |   | 50%                   |                                                                |
| - Conservative Procedures (Non-surgical)                                  |   |                       | 1 every 24 months per quadrant                                 |
| - Complex Procedures (Surgical)                                           |   |                       | 1 every 36 months per quadrant                                 |
| - Periodontal Maintenance Therapy                                         |   |                       | 2 in a benefit period aggregate with dental cleaning           |
| High Cost Restorations (Cast Restorations)                                |   | 50%                   |                                                                |
| - Cast Restorations                                                       |   |                       |                                                                |
| - Crowns                                                                  |   |                       | 1 every 7 years                                                |
| - Inlays                                                                  |   |                       | 1 every 7 years                                                |
| - Onlays                                                                  |   |                       | 1 every 7 years                                                |
| - Post and Cores                                                          |   |                       |                                                                |
| - Recementing Crowns/Inlays/Onlays                                        |   |                       |                                                                |
| Dentures and Bridges (Prosthetic Services)                                |   | 50%                   |                                                                |
| - Bridges                                                                 |   |                       | 1 every 7 years                                                |
| - Dentures                                                                |   |                       | 1 every 7 years                                                |
| - Repairs and Adjustments                                                 |   |                       |                                                                |
| - Recementing of Bridges                                                  |   |                       |                                                                |
| - Implants                                                                |   |                       | 1 every 7 years                                                |
| Straighter Teeth (Orthodontics)                                           |   | 50%                   |                                                                |
| Additional Options                                                        |   |                       |                                                                |
| -Enhanced Benefits Program                                                |   | Included              |                                                                |
| -Annual Maximum Carryover - To Go <sup>SM</sup>                           |   | Included              |                                                                |

\*Deductible applies to Consultations and X-Rays (Occlusal, ExtraOral, and Periapical).

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 Go<sup>SM</sup> 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.