DELTA DENTAL®

Delta Dental of Iowa
Seniors on the Move

Employee Summary of Covered Services and Benefits

Deductibles, Maximums & Eligibility	Delta Dental PPO℠	Delta Dental Premier®	Non Participating
- Individual Deductible	$25	$50	$50
- Deductible applies to Check-Ups and Teeth Cleaning?	No	Yes	Yes
- Benefit Period Maximum	$2,000	$2,000	$2,000
- Eligible children to age	26	26	26
- Full-time (unmarried) students eligible to age	99	99	99
Benefits			
Diagnostic and Preventive Services (Check-Ups and Teeth Cleaning)	0%	10%	30%
- Dental Cleaning			
- Oral Evaluations			
- Fluoride Applications			
- X-Rays			
- Sealant Applications			
- Space Maintainers			
- Periodontal Maintenance Therapy			
Routine and Restorative Services (Cavity Repair and Tooth Extractions)	20%	30%	50%
- Emergency Treatment			
- General Anesthesia/Sedation			
- Restoration of Decayed or Fractured Teeth			
- Limited Occlusal Adjustments			
- Routine Oral Surgery			
- Posterior Composites w/o Alternate Processing	50%	60%	70%
Root Canals (Endodontic Services)	50%	50%	60%
- Apicoectomy			
- Direct Pulp Cap			
- Pulpotomy			
- Retrograde Fillings			
- Root Canal Therapy			
Gum and Bone Diseases (Periodontal Services)	50%	50%	60%
- Conservative Procedures (Non-surgical)			
- Complex Procedures (Surgical)			
- Athletic Mouth Guard	50%	50%	50%
High Cost Restorations (Cast Restorations)	50%	50%	60%
- Cast Restorations			
- Crowns			
- Inlays			
- Onlays			
- Post and Cores			
- Recementing Crowns/Inlays/Onlays			
Dentures and Bridges (Prosthetic Services)	50%	50%	60%
- Bridges			
- Dentures			
- Repairs and Adjustments			
- Recementing of Bridges			
- Implants	60%	60%	70%
Straighter Teeth (Orthodontics)	Not Covered	Not Covered	Not Covered

Additional Options			
-Enhanced Benefits Program	Included	Included	Included
-Annual Maximum Carryover - To Go℠	Included	Included	Included

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℠ 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.

515-225-1455

2024 Seniors on the Move Dental Rates – PPO plus Premier Plan B Prime

The below dental rates are effective January 1, 2024 through December 31, 2024.

Member (Age 21+)	**Member/Spouse**	**Member/Children** (< Age 21)	**Family**
$43.46	$80.10	$77.04	$128.10

*Child coverage is up to age 21 as of the group's effective/renewal date.