Delta Dental of Iowa
Camanche Community School District

Employee Summary of Covered Services and Benefits

Deductibles, Maximums & Eligibility	Delta Dental PPO℠	Delta Dental Premier®	Non Participating	
- Individual Deductible	$25	$25	$25	
- Family Deductible	$75	$75	$75	
- Deductible applies to Check-Ups and Teeth Cleaning	No	No	No	
- 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%	0%	0%	
- Dental Cleaning				1 every 6 months aggregate with perio maintenance therapy
- Oral Evaluations				1 every 6 months
- Fluoride Applications				2 every 12 months
- X-Rays				Bitewings - 1 every 12 months; Full mouth - 1 every 3 years
- Space Maintainers *	20%	20%	20%	
Routine and Restorative Services (Cavity Repair and Tooth Extractions)	20%	20%	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%	20%	
- Apicoectomy				
- Direct Pulp Cap				
- Pulpotomy				
- Retrograde Fillings				
- Root Canal Therapy				
Gum and Bone Diseases (Periodontal Services)	20%	20%	20%	
- Conservative Procedures (Non-surgical)				1 every 24 months per quadrant
- Periodontal Maintenance Therapy				1 every 6 months aggregate with dental cleaning
High Cost Restorations (Cast Restorations)	20%	20%	20%	
- Cast Restorations				
- Crowns				1 every 5 years
- Inlays				1 every 5 years
- Onlays				1 every 5 years
- Post and Cores				
- Recementing Crowns/Inlays/Onlays				
Dentures and Bridges (Prosthetic Services)	Not Covered	Not Covered	Not Covered	
- Bridges				
- Dentures				
- Repairs and Adjustments				
- Recementing of Bridges				
- Implants				
Straighter Teeth (Orthodontics)	Not Covered	Not Covered	Not Covered	

*Deductible applies to Space Maintainers.

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.

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