Iowa Association of REALTORS®

2024 IAR DENTAL AND VISION INSURANCE

PATTON
Insurance Benefits
Experts in Health Benefits

PATTON INSURNACE BENEFITS

1112 MAPLE ST
WEST DES MOINES IA, 50265

PHONE: 515-270-8178
TOLL: 800-798-6772
FAX: 515-270-0398
EMAIL: MAIL@PATTONBENEFITS.COM

PROVIDED BY

DELTA DENTAL®

Iowa Association of REALTORS®

Dental care is smart health care.

Preventive dental care helps protect your smile, can provide early detection of more than 120 diseases[1] and can offer long-term savings. Delta Dental offers you and your family a choice when it comes to your dental care. Your employer has made it easy for you to get the dental coverage you need by providing convenient, pre-tax premium deductions from your paycheck.

Select your coverage.

Delta Dental's plans give you the flexibility to get the coverage you need and use.

- Preventive – Basic plan; covers preventive services and cavity repair.
- Preferred – Covers preventive, restorative and major services with an annual benefit maximum of $1,000.
- Platinum – Richest benefits; covers preventive, restorative and major services with an annual benefit maximum of $2,000.

The chart on the right shows how much you would pay for certain dental services when you see a Delta Dental PPO or Premier dentist.

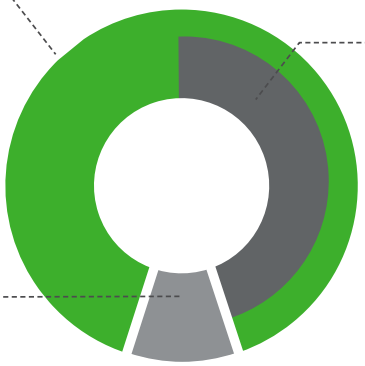
	Preventive	Preferred	Platinum
Annual Benefit Maximum per person	No limit	$1,000	$2,000
Deductible per person	$50	$50-150	$25-100
Diagnostic and Preventive (exams, cleanings, X-rays)	20-30%*	0%	0-20%
Routine & Restorative Services (cavity repair, extractions)	50%**	50%	20-40%
Major Services (root canal, bridges, crowns)	Not covered	50%	50%
Monthly Premium	$	$$	$$$

*Diagnostic and preventive services apply to deductible for the Preventive plan. **Oral surgery and extractions are not covered under the Preventive plan.

Choose your dentist and your savings.

These plans are based on Delta Dental's PPO plus Premier network. You can see any dentist you wish, but will have greater cost savings by seeing a Delta Dental PPOSM or Delta Dental Premier® dentist.

DELTA DENTAL PREMIER DENTISTS
Includes over 90 percent of Iowa dentists2, with out-of-pocket costs and reduced benefits.



DELTA DENTAL PPOSM DENTISTS
Includes over 40 percent of Iowa dentists2, with the out-of- pocket costs and best benefits.

OUT-OF-NETWORK DENTISTS
Allows you to see an out-of-network dentist at higher costs and with reduced benefits.

DELTA DENTAL®

[1] Journal of the American Dental Association, Vol 134, No suppl_1, 41S-48S. 2003.
[2] NetMinder, 2018.

Iowa Association of REALTORS®

DELTA DENTAL®

Preventive Plan	Delta Dental PPO Dentist	Delta Dental Premier® Dentist	Out-of-Network Dentist
Deductible per person per calendar year	$50	$50	$75
Diagnostic and Preventive Care (exams, cleanings, X-rays)	20%	30%	50%
Routine and Restorative Services (fillings, cavity repair)	50%**	50%**	70%**
Posterior Composites (tooth-colored filling on back teeth)	50%	50%	70%
Endodontics and Periodontics (root canals, gum and bone disease, crowns, dentures, bridges)	Not covered	Not covered	Not covered
Implants	Not covered	Not covered	Not covered
Annual Benefit Maximum per person per calendar year	Unlimited		

Monthly Premium: Single: $16.14 Two-Person: $31.18 Family: $63.62

Preferred Plan	Delta Dental PPO Dentist	Delta Dental Premier® Dentist	Out-of-Network Dentist
Deductible per person per calendar year	$50*	$150*	$225
Diagnostic and Preventive Care (exams, cleanings, X-rays)	0%	0%	50%
Routine and Restorative Services (fillings, tooth extractions, oral surgery)	50%	50%	70%
Posterior Composites (tooth-colored filling on back teeth)	60%	60%	70%
Endodontics (root canals)	50%	50%	70%
Periodontics (gum and bone disease, crowns, dentures, bridges)	50%	50%	70%
Implants	60%	60%	70%
Annual Benefit Maximum per person per calendar year	$1,000		

Monthly Premium: Single: $31.56 Two-Person: $60.78 Family: $113.24

Platinum Plan	Delta Dental PPO Dentist	Delta Dental Premier® Dentist	Out-of-Network Dentist
Deductible per person per calendar year	$25*	$100*	$175
Diagnostic and Preventive Care (exams, cleanings, X-rays)	0%	20%	40%
Routine and Restorative Services (fillings, tooth extractions, oral surgery)	20%	40%	60%
Posterior Composites (tooth-colored filling on back teeth)	50%	60%	70%
Endodontics (root canals)	50%	50%	60%
Periodontics (gum and bone disease, crowns, dentures, bridges)	50%	50%	60%
Implants	60%	60%	70%
Annual Benefit Maximum per person per calendar year	$2,000		

Monthly Premium: Single: $40.28 Two-Person: $77.92 Family: $145.40

** There is a 24 month waiting period to re-enroll if coverage is dropped.

* Deductible is waived for diagnostic and preventive services.
** Extractions and oral surgery are not covered under the Preventive Plan.

Rates effective June 1, 2024 through May 31, 2025

Percentages shown are what the patient pays. For example, if the patient's coinsurance is 20%, Delta Dental pays 80%.
Annual open enrollment allowed. No late entrants permitted, unless there is a qualifying event.
Not a full description of benefits. Please see your benefit certificate for complete coverage details.

DeltaVision®

Iowa Association of REALTORS®

SUMMARY OF COVERED SERVICES AND BENEFITS

$150 Frame Allowance / $25 Lens Copay / Fit and Follow-Up – Insight Network

Benefit Frequency	
Contact Lenses or Lens	Once every calendar year.
Exam	Once every calendar year.
Frame	Once every two calendar years.

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam		
Exam	$10 Copay	Up to $35
Dilation	$0	N/A
Eye Exam Refraction	$0	N/A
Lens		
Single Vision	$25 Copay	Up to $25
Bi-focal	$25 Copay	Up to $40
Tri-focal	$25 Copay	Up to $55
Standard Progressive Lens	$90 Copay	Up to $40
Premium Progressive Lens	Premium Progressive as follows:	Up to $40
Tier 1	$110	
Tier 2	$120	
Tier3	$135	
Tier 4	80% of Charge less $120, plus $90 Copay	
Lenticular	$25 Copay	Up to $55
Other Lens Type	80% of Charge	N/A
Frame		
Frame	80% of Balance over $150	Up to $75
Lens Options		
Standard Polycarbonate	$40 Copay	N/A
Standard Plastic Scratch Coating	$15 Copay	N/A
Tint	$15 Copay	N/A
UV Treatment	$15 Copay	N/A
Standard Anti-reflective (a/r) Coating	$45 Copay	N/A
Premium Anti-reflective (a/r) Coating	Premium Anti-reflective Coating as follows:	N/A
Tier 1	$57	N/A
Tier 2	$68	N/A
Tier 3	80% of Retail	N/A
Photochromatic/Transitions	$75	N/A
Other Lens Options	80% of Charge	N/A
Contact Lenses		
Contact Lens — Conventional	85% of Balance over $150	Up to $120
Contact Lens — Disposable	Balance over $150	Up to $120
Standard Fit And Follow Up Exam	$0 Copay	Up to $40
Premium Fit And Follow Up Exam	$0 Copay, 10% off retail price then apply $55 allowance	Up to $40
Medically Necessary Contacts	$0	Up to $200
Non-Scheduled Items		
Doctor Misc. Materials	80% of Charge	N/A
LASIK or PRK Vision Correction	85% of Retail Price or 95% of Promotional Price	N/A

Single	**$8.84**
Employee / Spouse	**$15.92**
Employee / Child(ren)	**$17.90**
Family	**$23.32**

DELTA DENTAL

Iowa Association of REALTORS®

Small Business Enrollment/Change Form

☐ New Applicant ☐ Change of Coverage ☐ Name/Address Change

(Completed by Employer)

Group Number _____ **Effective Date** ___/___/___ **Department/EE Number** _____

1 POLICYHOLDER INFORMATION

Name (First, Middle Initial, Last) _____ **Social Security Number** _____

Mailing Address _____ **City** _____ **State** _____ **Zip** _____

Status ☐ Single ☐ Married ☐ Other (specify) _____ **IAR License Date** ___/___/___

Telephone (_____)_____ ☐ Home ☐ Cell Phone

Email Address _____

☐ *I agree to receive information via email messages.**

Employer Name Iowa Associaiton of Realtors **Employer Location** West Des Moines, IA

Dental Product Choice:

☐ Preventive ☐ Preferred ☐ Platinum

Vison Product Choice:

☐ Employee ☐ EE/Child(ren) ☐ EE/Spouse ☐ Family

2 ELIGIBLE MEMBERS ELECTING COVERAGE

List self & eligible members to be covered First Name MI Last (if different)	Social Security Number	Birthdate	Sex	Coverage Selected	Full-Time College Student	Disabled Status	Other Dental Coverage
Self		___/___/___	☐ M ☐ F	☐ Dental ☐ Vision		☐ Yes ☐ No	☐ No ☐ Yes
Spouse		___/___/___	☐ M ☐ F	☐ Dental ☐ Vision		☐ Yes ☐ No	☐ No ☐ Yes
Eligible Child		___/___/___	☐ M ☐ F	☐ Dental ☐ Vision	☐ Yes ☐ No School Name:	☐ Yes ☐ No	☐ No ☐ Yes
Eligible Child		___/___/___	☐ M ☐ F	☐ Dental ☐ Vision	☐ Yes ☐ No School Name:	☐ Yes ☐ No	☐ No ☐ Yes
Eligible Child		___/___/___	☐ M ☐ F	☐ Dental ☐ Vision	☐ Yes ☐ No School Name:	☐ Yes ☐ No	☐ No ☐ Yes

Other Dental Coverage – if any person(s) on this application has other dental insurance please complete.

Policyholder _____

Name of Other Carrier(s) _____ Policy Number _____ Effective Date ___/___/___ Contract Type ☐ **Single** ☐ **Family**

3 CHANGE OF COVERAGE

Please check events requiring Contract changes:

☐ **Marriage** ☐ **Death** ☐ **Divorce** ☐ **Birth/Adoption** ☐ **Drop Covered Person** ☐ **COBRA** ☐ **Terminating Benefits**

☐ **Other** (explain) _____ Name of Affected Party _____ Date of Event ___/___/___

4 AGREEMENT AND CERTIFICATION

I have read and understand the Agreement and Certification and/or Waiver of Coverage language on the back of this application and acknowledge receipt of a fully completed copy of this application.

ACCEPTANCE/WAIVER OF COVERAGE

☐ I accept the dental and/or vision coverage selected above.

☐ I waive dental coverage for my family members and/or myself. (Please indicate reason) _____

☐ I waive vision coverage for my family members and/or myself. (Please indicate reason) _____

X _____ ___/___/___

Employee Signature Date

*I provide my consent to Delta Dental of Iowa to contact me by email about Delta Dental products and services that may be available to me. I give Delta Dental permission to use my personal information to determine the types of products and services that may be offered to me. I understand I may revoke this consent at any time by contacting Delta Dental at TeamService@deltadentalia.com or 1-877-423-3528.

PATTON
Insurance Benefits
Experts in Health Benefits

Iowa Association of REALTORS®

ACCOUNT WITHDRAWAL AUTHORIZATION

I (we) hereby authorize Associations Marketing Group Inc to initiate debit entries to the account indicated below, and the financial institution named below, to debit the same to such account.

This authorization is for the purpose of paying monthly premiums for Delta Dental benefits, and I understand that the amounts are subject to change upon prior written notification to me at least 30 days in advance of any rate adjustment.

Monthly Withdrawal Date: ❒ 5th of month

Bank Information:

_____ _____
Name of Financial Institution Branch (if applicable)

_____
Address of Financial Institution City State Zip Code

Account Type:

❒ Checking – please attach a voided check
❒ Savings – please attach a pre-printed deposit slip, or indicate:

Bank Routing Number _____ Account Number _____

This authority is to remain in full force and effect until Delta Dental of Iowa has received written notification from me (us) of its termination in such time and manner as to afford Delta Dental and the above named financial institution a reasonable opportunity to act on it.

_____ _____
Please Print Name of Insured Delta Dental ID Number (Social Security Number)

_____ _____
Signature of Insured Date Signed

Please return this completed form to:
Patton Insurance Benefits
1112 Maple St
West Des Moines IA, 50265
Fax: 515-270-0398
Email: Mail@pattonbenefits.com

Have you attached a voided personal check or a pre-printed personal savings account deposit slip from your financial institution?