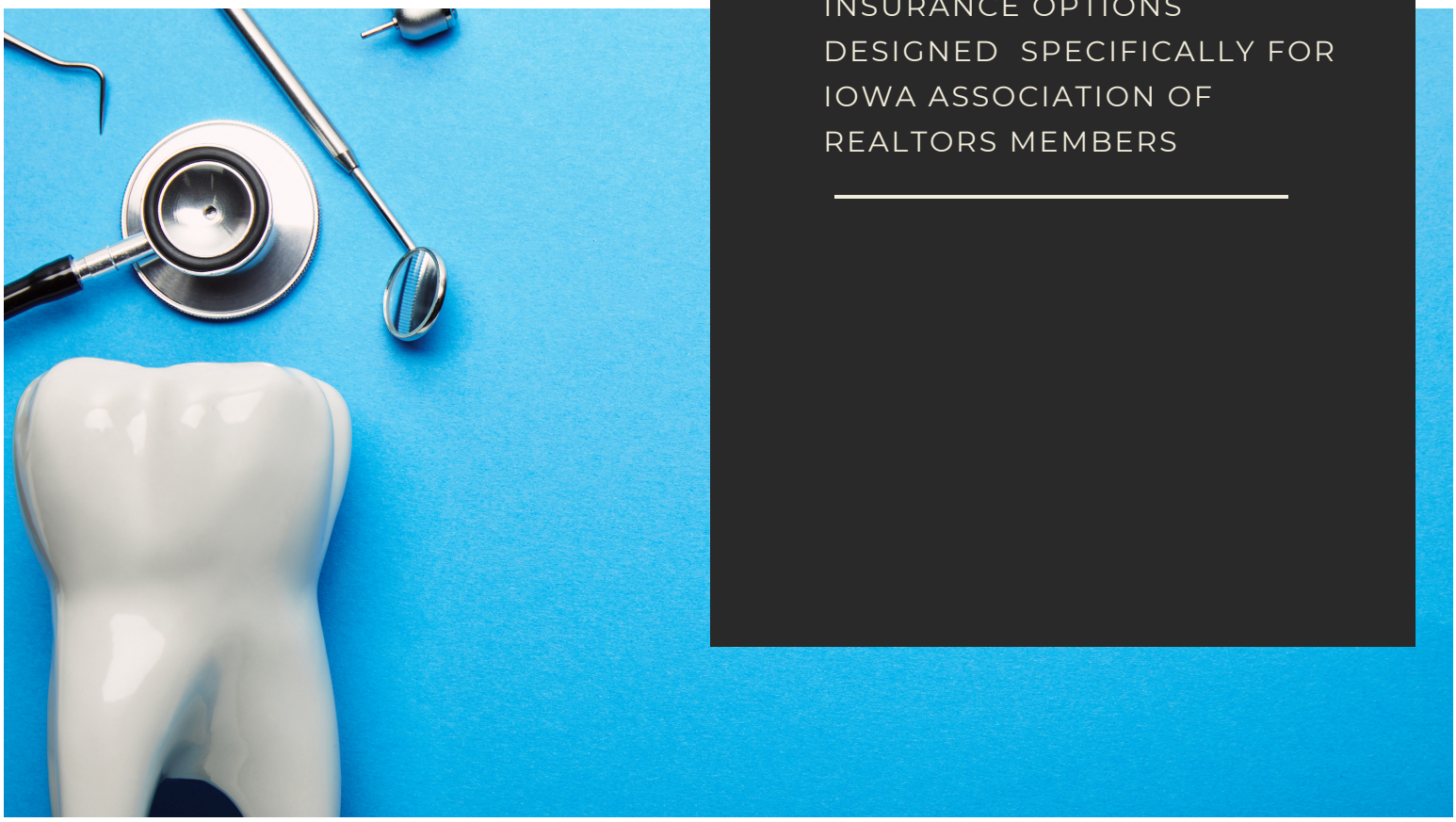
Iowa Association of REALTORS®

DENTAL VISION INSURANCE

INSURANCE OPTIONS DESIGNED SPECIFICALLY FOR IOWA ASSOCIATION OF REALTORS MEMBERS



ASSOCIATIONS MARKETING GROUP INC

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PROVIDED BY

AMGi Associations Marketing Group, Inc.
Expertise in Health Benefits.

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.

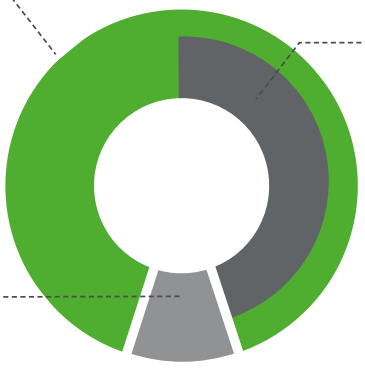
	Preventive	Preferred	Platinum
Annual Benefit Maximum per person	No limit	$1,000	$2,000
Deductible per person	$50	$50-150	$25-100
Diagnostic and Preventive (exams, cleanings, X-rays)	20-30%*	0%	0-20%
Routine & Restorative Services (cavity repair, extractions)	50%**	50%	20-40%
Major Services (root canal, 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 PPO℠ or Delta Dental Premier® dentist.

DELTA DENTAL PREMIER® DENTISTS
Includes over 90 percent of Iowa dentists[2], with **lower** out-of-pocket costs and reduced benefits.



DELTA DENTAL PPO℠ DENTISTS
Includes over 40 percent of Iowa dentists[2], with the **lowest** 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.

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

DELTA DENTAL®

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: $13.70 Two-Person: $26.32 Family: $53.58

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: $26.64 Two-Person: $51.18 Family: $95.22

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: $33.98 Two-Person: $65.56 Family: $122.22

** 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 2021 through May 31, 2022
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®

Broad network.
Flexible solutions.
The easy choice.

For companies with up to 500 employees

Why offer vision coverage?

Healthy employees are happy, productive employees — and vision care is an essential part of health and wellness. A vision exam can detect everything from eyestrain to diabetes to high blood pressure[1]. In addition, **2/3 of employees would trade a vacation day for vision coverage[2].** Offering vision coverage as part of your benefits package is a great way to recruit and retain staff.

The need for vision care is easy to see:

- **75%** of adults use some form of vision correction[3]
- **10 million children** suffer from undetected vision problems[4]
- The average American adult spends **11 of 18 waking hours** looking at a screen[5]

PROPER EYE CARE
DELIVERS
$7,800
IN ADDED
PRODUCTIVITY
PER EMPLOYEE[6]

DeltaVision® has you covered.

DeltaVision supports your business with vision care programs designed to deliver long-term value and satisfied employees. Management of your program is simple with the full support of our highly experienced team, along with access to our secure online tools and resources. Add in Iowa's most diverse network of independent and retail providers, and you can see how **DeltaVision makes eyecare coverage easy.**

- **Locally:** offered by Delta Dental of Iowa since 2009
- Covers more than **800 small and large group customers** in Iowa
- **Nationally:** largest network in the U.S. — with more than 40 million covered members and 74,000 providers
- Offers a **diverse network**, with a choice of independent and retail providers
- Provides **additional benefits** for certain medical conditions
- Includes a **variety of plans**, each available on a voluntary or contributory basis
- Provides **hearing discounts** on exams and hearing aids as well as free batteries for two years
- Allows members to access dental and vision benefits in one place with **Delta Dental Member Connection**

DELTA DENTAL®

[1]Thompson Media Inc., Employee Benefit News [2]National Eye Institute [3]VisionExpo summary of the Vision Council report
[4]National Parent Teacher Association [5]The Total Audience Report; Q4 2014, Nielsen, March 2015 [6]Vision Council's 2015 Digital Eye Strain report

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	**$8.68**
Employee / Spouse	**$15.62**
Employee / Child(ren)	**$17.56**
Family	**$22.88**

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.

DELTA DENTAL OF IOWA
ACCOUNT WITHDRAWAL AUTHORIZATION

I (we) hereby authorize Delta Dental of Iowa 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:
Associations Marketing Group Inc.
1112 Maple St
West Des Moines IA, 50265
Fax: 515-270-0398
Email: Mail@amgi-dsm.com

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

AGREEMENT AND CERTIFICATION

I certify I am legally authorized to apply for coverage for myself and/or for all other persons named in this application. I understand I am applying for coverage sponsored by my employer or Plan Sponsor offered by Delta Dental of Iowa ("Delta Dental") and/or Veratrus Benefits Solutions, Inc. ("VBS"). I authorize my employer, to deduct from my pay or collect from me in advance the premium therefore and remit such sums to Delta Dental on my behalf. This authorization is to remain in effect until I, or my employer or Plan Sponsor, notifies Delta Dental to the contrary. I understand coverage for the dental and/or vision policy applied for will not start until after this application and the monies for the first month's premium are deducted from my pay or paid to my employer, and are received and accepted by Delta Dental. I further understand that Delta Dental establishes the effective date of the policy. I also understand the amounts are subject to change at least annually and my employer or Plan Sponsor will furnish written notice of such changes to me.

I certify that after this application was completed, I carefully and fully read it, that the statements and answers set forth are full, true, and correct, to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that Delta Dental will rely upon the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or have concealed any material fact, Delta Dental will be entitled to declare the dental and/or vision policy applied for void and refuse allowance of benefits to any person thereunder.

I authorize any health care provider to release medical records to Delta Dental and VBS when reasonably related to the dental and/or vision coverage for which I have applied for. If any law or regulation requires additional authorization for release of dental and/or vision records, I will give this authorization.

WAIVER OF COVERAGE

I understand if I decide not to apply for coverage, or if I apply only for myself even though coverage is available for eligible members of my family, any subsequent application will be subject to the applicable terms and conditions of the Group Insurance Policy to provide dental and/or vision benefits, which may require additional limitations and waiting periods. I also understand Delta Dental reserves the right to reject such an application.

NONDISCRIMINATION AND ACCESSIBILITY

Delta Dental of Iowa complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. To review our full non-discrimination notice, please go to www.deltadentalia.com/nondiscrimination.

DeltaVision is offered through and underwritten by Veratrus Benefit Solutions, Inc., a wholly-owned subsidiary of Delta Dental of Iowa.

2533-A10022 03/2020

DELTA DENTAL®

Required Federal Notice-Nondiscrimination and Accessibility

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Delta Dental of Iowa provides free language services to people whose primary language is not English. In addition, Delta Dental provides free services for people with disabilities such as auxiliary aids, written communication in other formats such as large print, audio or other formats. If you need these services, call 1-877-983-3582, hearing impaired (TYY) call 1-888-287-7312.

Language Access Service

If you, or someone you're helping, has questions about Delta Dental of Iowa, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-877-983-3582.

Arabic –

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Delta Dental of Iowa، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-877-983-3582.

Chinese – 如果您，或是您正在協助的對象，有關於 Delta Dental of Iowa 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請致電 1-877-983-3582

French – Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Delta Dental of Iowa, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-877-983-3582.

German – Falls Sie oder jemand, dem Sie helfen, Fragen zum Delta Dental of Iowa haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-877-983-3582 an.

Hindi – यदि आपके, या आप द्वारा सहायता किए जा रहे किसी व्यक्ति के Delta Dental of Iowa के बारे में प्रश्न हैं, तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। किसी दुभाषिए से बात करने के लिए 1-877-983-3582 पर कॉल करें।

Karen – နၤ, မ့တမ့ၢ် ပှၤတဂၤဂၤလၢနမၤစၢၤအိၤ, မ့ၢ်အိဉ်ဒီး တၢ်သံကွၢ်တဖဉ်ဘဉ်ယးဒီးDelta Dental of Iowa နှဉ်,နအိဉ်ဒီး တၢ်ခွဲးတၢ်ယာ်လၢနကဒီးန့ၢ်ဘဉ်တၢ်မၤစၢၤဒီး တၢ်ဂ့ၢ်တၢ်ကျိၤလၢ နကျိာ်ဒဉ် နဲလၢ တလိဉ်ဟ့ဉ်ဇဟူးဘဉ်နှဉ်လိၤ. လၢနက ကတိၤတၢ်ဒီး ပှၤကတိၤကျိာ်ထံတၢ်ဇဂီၢ်, ကိး1-877-983-3582တက့ၢ်.

Korean – 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Delta Dental of Iowa에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-877-983-3582로 전화하십시오.

Laotian – ຖ້າທ່ານ ຫຼືຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ ມີຄຳຖາມກ່ຽວກັບ Delta Dental of Iowa, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອໂອ້ລົມກັບນາຍພາສາ, ໃຫ້ໂທຫາ 1-877-983-3582.

Pennsylvania Dutch: Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Delta Dental of Iowa, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 1-877-983-3582 uffrufe.

Russian – Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Delta Dental of Iowa, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-877-983-3582.

Serbo-Croatian – Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Delta Dental of Iowa, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 1-877-983-3582.

Spanish – Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Delta Dental of Iowa, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-983-3582.

Tagalog – Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Delta Dental of Iowa, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-877-983-3582.

Thai – หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Delta Dental of Iowa คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 1-877-983-3582

Vietnamese – Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Delta Dental of Iowa, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-877-983-3582.