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.

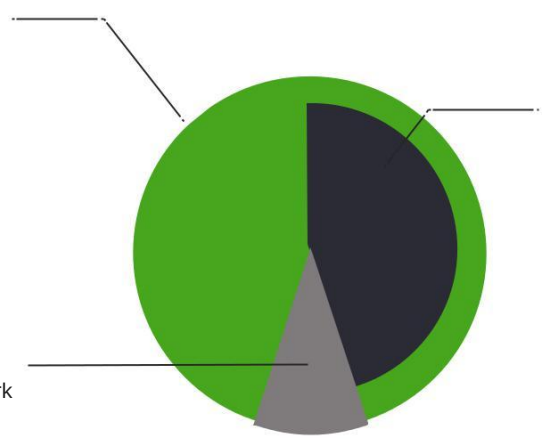
	Preventive	Preferred	Platinum
Annual Benefit Maximum per person	No limit	$1,000	$2,000
Deductible per person	$50	$50-150	$25-100
Diagnostic and Preventive (exams, cleanings, X-rays)	20-30%*	0%	0-20%
Routine & Restorative Services (cavity repair, extractions)	50%**	50%	20-40%
Major Services (root canal,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

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: $15.08 | Two-Person: $30.06 | Family: $62.42

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: $30.46 | Two-Person: $59.58 | Family: $111.86

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: $39.14 | Two-Person: $76.64 | Family: $143.90

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

Rates effective July 1, 2025 through June 30, 2026
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.

DELTA DENTAL

Large Employer Group Enrollment/Change Form

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

Employee Choice

(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) _____ **Hire Date** ___/___/___

Telephone (_____)_____ ☐ Home ☐ Cell Phone **Email Address** _____

Employer Name _____ **Employer Location** _____

Plan Choice ☐ Preventive ☐ Preferred ☐ Platinum

2 ELIGIBLE MEMBERS ELECTING COVERAGE

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

☐ **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 coverage selected above.

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

X _____ ___/___/___

Employee Signature Date

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"). 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 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 when reasonably related to the dental 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 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.