Association Benefit Program

Dental and Vision Plans

Benefit Program administered by IRON REHEALTH an Arsenal company

Open Network

Dental
Per Calendar Year

- Deductible (Individual/Family): $50 /$150
- Maximum: $1,000
- Basic Diagnostic/Preventative Services: 100%
- Basic Restorative Services: 100%
- Supplemental Services: 100%
- Prosthetic Services: 50%
- Periodontics Services: 80%

Dental Rates

- Employee $23
- Employee + 1 $46
- Employee + Family $79

Vision
Per Calendar Year

- Glasses or Contacts: $200 Maximum
- Maximum (Individual/Family) $500/$1,000
- Annual Basic Eye Exam: $15 copay
- Contact Lenses: $25 copay
- Glasses: $25 copay

Vision Rates

- Employee $17
- Employee + 1 $31
- Employee + Family $43

*Rates subject to change.

info@ironrehealth.com 334-245-1099 ironrehealth.com

Iron ReHealth Dental Plan

Summary of Benefits

General Provisions	Calendar Year Deductible Calendar Year Maximum	$50 deductible per member per calendar year. $150 aggregate family maximum. $1,000 per member each calendar year.
Basic Diagnostic and Preventative Services	Covered at 100% of the allowed amount, subject to the calendar year deductible.	· Dental exams up to twice per calendar year. · Full mouth x-rays, one set during any 36 in a row. · Bitewing x-rays, once per calendar year. · Other dental x-rays, used to diagnose a specific condition. · Routine cleanings, twice per calendar year. · Tooth sealants on teeth 3, 14, 19, and 30, limited to one application per tooth each 48 months. Benefits are limited to a maximum payment of $20 per tooth. Limited to the first permanent molars of children through age 13. · Fluoride treatment for children through age 18 twice per calendar year. · Space maintainers (not made of precious metals) that replace prematurely lost teeth for children through age 18.
Basic - Restorative Services	Covered at 100% of the allowed amount, subject to the calendar year deductible.	· Fillings made of silver amalgam and synthetic tooth color materials (tooth color materials include composite fillings on the front upper and lower teeth 5-12 and 21-28; payment allowance for composite fillings used on posterior teeth is reduced to the allowance given on amalgam fillings). · Simple tooth extractions. · Direct pulp capping, removal of pulp and root canal treatment. · Repairs to removable dentures. · Emergency treatment for pain.
Supplemental Services	Covered at 100% of the allowed amount, subject to the calendar year deductible.	· Oral surgery to diagnose and treat mouth cysts and abscesses and for tooth extractions and impacted teeth. · Oral surgery for tooth extractions and impacted teeth and to treat mouth abscesses of the intra-oral and extra-oral soft tissue. · General anesthesia given for oral or dental surgery. This means drugs injected or inhaled for relaxation or to lessen pain, or to make unconscious, but not analgesics, drugs given by local infiltration, or nitrous oxide. · Treatment of the root tip of the tooth including its removal.
Prosthetic Services	Covered at 50% of the allowed amount, subject to the calendar year deductible.	· Full or partial dentures. · Fixed or removable bridges. · Inlays, onlays, veneers or crowns to restore diseased or accidentally broken teeth, if less expensive fillings will not restore the teeth.
Periodontic Services	Covered at 80% of the allowed amount, subject to the calendar year deductible.	· Periodontic exams twice each 12 months. · Removal of diseased gum tissue and reconstructing gums. · Removal of diseased bone. · Reconstruction of gums and mucous membranes by surgery. · Removing plaque and calculus below the gum line for periodontal disease.

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Providers and members should submit claims to:

Iron ReHealth | Dental Claims | 5151 Hampstead High St, Ste 200 | Montgomery, AL 36116 | (334) 245-1099

Iron ReHealth Vision Plan

Summary of Benefits

Benefit	Copay	Frequency
Annual Basic Exam Basic eye exam (1)	$15	Per calendar year
Prescription Glasses and Contacts $200 maximum allowable benefit for either contact lenses or glasses		
Contact Lenses (3) • Contact lense fitting included with paid copay • $200 maximum allowable benefit for either contact lenses or glasses/glass lenses	$25	Per calendar year
Glasses (3) • You may choose from any standard or designer frames and lenses of your choice up to the covered amount. (2) • Options such as progressive lenses, tint, UV, etc. may be available at discounted rates at some providers. • $200 maximum allowable benefit for either glasses/glass lenses or contact lenses	$25	Per calendar year
Maximum Benefit $500 maximum allowable benefit per person $1000 maximum allowable benefit per family		

Network is open to any vision provider. In the event provider will not file with the vision plan, member pays full fee to provider and Vision Plan reimburses member for services rendered up to the maximum allowance. All receipts must be submitted at the same time and at the time the reimbursement is filed. Reimbursements must be submitted within 90 days and Vision Plan reserves the right to deny any claims that do not provide sufficient proof.

(1) Refraction and retinal screening not included
(2) Amounts greater than the allowance are the responsibility of the member
(3) $200 maximum allowable benefit for either contact lenses or glasses/glass lenses

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