2020 Dental and Vision Rates

Rates are guaranteed for two years for new groups.*

EMPLOYER CHOICE PPO plus PREMIER PRIME DENTAL PLANS

PPO plus PREMIER PLAN A PRIME

	Per-Person Rates			Four-Tier Rates					
# of Eligible EEs**	Adult	Child	Child with Ortho	Single	Employee/ Spouse	Employee/ Child(ren)	Family	Employee/Child(ren) with Ortho	Family with Ortho
Base Rate/1-9	$25.30	$15.72	$17.98	$23.74	$49.54	$43.88	$70.50	$52.62	$82.72
10-50	$22.90	$14.24	$16.30	$22.42	$47.74	$42.36	$68.04	$50.78	$79.78

PPO plus PREMIER PLAN B PRIME

	Per-Person Rates			Four-Tier Rates					
# of Eligible EEs**	Adult	Child	Child with Ortho	Single	Employee/ Spouse	Employee/ Child(ren)	Family	Employee/Child(ren) with Ortho	Family with Ortho
Base Rate/1-9	$32.78	$21.18	$24.80	$31.78	$68.14	$60.48	$97.42	$74.60	$117.20
10-50	$29.72	$19.18	$22.48	$29.72	$63.70	$56.54	$91.04	$69.74	$109.52

PPO plus PREMIER PLAN C PRIME

	Per-Person Rates			Four-Tier Rates					
# of Eligible EEs**	Adult	Child	Child with Ortho	Single	Employee/ Spouse	Employee/ Child(ren)	Family	Employee/Child(ren) with Ortho	Family with Ortho
Base Rate/1-9	$28.46	$22.48	$26.54	$27.60	$59.70	$52.98	$85.60	$65.52	$103.16
10-50	$25.78	$20.36	$24.06	$25.78	$55.78	$49.50	$80.00	$61.22	$96.40

EMPLOYER CHOICE PREMIER PRIME DENTAL PLANS

PREMIER PLAN A PRIME

	Per-Person Rates			Four-Tier Rates					
# of Eligible EEs**	Adult	Child	Child with Ortho	Single	Employee/ Spouse	Employee/ Child(ren)	Family	Employee/Child(ren) with Ortho	Family with Ortho
Base Rate/1-9	$28.86	$18.74	$20.40	$27.70	$58.96	$52.22	$83.90	$62.62	$98.46
10-50	$26.72	$16.96	$18.50	$26.72	$56.86	$50.38	$80.92	$60.40	$94.96

PREMIER PLAN B PRIME

	Per-Person Rates			Four-Tier Rates					
# of Eligible EEs**	Adult	Child	Child with Ortho	Single	Employee/ Spouse	Employee/ Child(ren)	Family	Employee/Child(ren) with Ortho	Family with Ortho
Base Rate/1-9	$42.90	$29.94	$33.56	$40.82	$83.06	$74.12	$117.02	$90.58	$140.04
10-50	$38.86	$27.12	$30.42	$38.86	$79.10	$70.60	$111.46	$86.26	$133.40

PREMIER PLAN C PRIME

	Per-Person Rates			Four-Tier Rates					
# of Eligible EEs**	Adult	Child	Child with Ortho	Single	Employee/ Spouse	Employee/ Child(ren)	Family	Employee/Child(ren) with Ortho	Family with Ortho
Base Rate/1-9	$36.92	$25.80	$29.84	$35.12	$72.80	$64.90	$103.20	$79.66	$123.86
10-50	$33.46	$23.34	$27.02	$33.46	$69.36	$61.82	$98.30	$75.88	$117.98

EMPLOYER CHOICE PLUS*** DENTAL PLANS

PPO plus PREMIER PLAN B PLUS

	Per-Person Rates		
# of Eligible EEs**	Adult	Child	Child with Ortho
Base Rate/1-9	$34.42	$26.08	$27.58
10-50	$31.20	$25.76	$27.24

PREMIER PLAN B PLUS

	Per-Person Rates		
# of Eligible EEs**	Adult	Child	Child with Ortho
Base Rate/1-9	$42.20	$31.00	$32.58
10-50	$38.60	$30.62	$32.18

*Effective January 1, 2020, and after. Rates are good for 24 months from initial enrollment as long as your plan does not change.
**For groups who contribute to premiums (contributory plans), and have a participation level of 50 percent or greater, rates are based on the number of eligible employees. For all other groups, the base rate applies.
***Delta Dental Employer Choice Plus Plans include the Affordable Care Act (ACA) pediatric dental essential health benefits (EHB).

DELTA DENTAL®

EMPLOYEE CHOICE DENTAL PLANS

Plan	Adult (21 and older)	Child (up to age 21)
Preventive Prime	$15.86	$15.34
Preventive Plus	$15.86	$30.90
Preferred Prime	$31.44	$24.12
Preferred Plus	$31.44	$36.84
Platinum Prime	$39.28	$30.12
Platinum Plus	$39.28	$36.84

VOLUNTARY VISION PLANS

	$10 Lens Copay			$25 Lens Copay			Materials Only		
Frame Allowance	$130	$150	$200	$130	$150	$200	$130	$150	$200
Fit and Follow-Up	Discounted / Funded	Discounted / Funded	Discounted / Funded	Discounted / Funded	Discounted / Funded	Discounted / Funded			
Four-Tier									
Single	$7.42 / $8.10	$7.82 / $8.72	$8.84 / $9.70	$6.68 / $7.32	$7.00 / $7.68	$8.12 / $8.86	$5.74	$6.10	$7.18
Employee/Spouse	$14.12 / $15.42	$14.88 / $16.62	$16.82 / $18.48	$12.74 / $13.92	$13.34 / $14.62	$15.46 / $16.88	$10.82	$11.54	$13.56
Employee/Child(ren)	$16.02 / $17.40	$16.88 / $18.82	$19.06 / $20.94	$14.44 / $15.78	$15.12 / $16.56	$17.50 / $19.14	$12.30	$13.08	$15.38
Family	$21.14 / $23.00	$22.30 / $24.84	$25.16 / $27.64	$19.08 / $20.84	$19.96 / $21.88	$23.12 / $25.26	$16.20	$17.22	$20.26
Three-Tier									
Single	$7.42 / $8.10	$7.82 / $8.72	$8.84 / $9.70	$6.68 / $7.32	$7.00 / $7.68	$8.12 / $8.86	$5.74	$6.10	$7.18
Two Person	$14.12 / $15.42	$14.88 / $16.62	$16.82 / $18.48	$12.74 / $13.92	$13.34 / $14.62	$15.46 / $16.88	$10.82	$11.54	$13.56
Family	$19.78 / $21.52	$20.84 / $23.26	$23.52 / $25.86	$17.84 / $19.48	$18.68 / $20.46	$21.62 / $23.64	$15.12	$16.12	$18.94
Two-Tier									
Single	$7.42 / $8.10	$7.82 / $8.72	$8.84 / $9.70	$6.68 / $7.32	$7.00 / $7.68	$8.12 / $8.86	$5.74	$6.10	$7.18
Family	$18.96 / $20.64	$20.00 / $22.28	$22.58 / $24.80	$17.12 / $18.70	$17.90 / $19.64	$20.74 / $22.66	$14.54	$15.46	$18.18

CONTRIBUTORY VISION PLANS

	$10 Lens Copay			$25 Lens Copay			Materials Only		
Frame Allowance	$130	$150	$200	$130	$150	$200	$130	$150	$200
Fit and Follow-Up	Discounted / Funded	Discounted / Funded	Discounted / Funded	Discounted / Funded	Discounted / Funded	Discounted / Funded			
Four-Tier									
Single	$5.66 / $6.18	$5.96 / $6.66	$6.74 / $7.40	$5.10 / $5.58	$5.34 / $5.86	$6.20 / $6.76	$4.38	$4.66	$5.48
Employee/Spouse	$10.78 / $11.76	$11.36 / $12.68	$12.84 / $14.10	$9.72 / $10.62	$10.18 / $11.16	$11.80 / $12.88	$8.26	$8.80	$10.34
Employee/Child(ren)	$12.22 / $13.28	$12.88 / $14.36	$14.54 / $15.98	$11.02 / $12.04	$11.54 / $12.64	$13.36 / $14.60	$9.38	$9.98	$11.74
Family	$16.14 / $17.56	$17.02 / $18.96	$19.20 / $21.20	$14.56 / $15.90	$15.24 / $16.70	$17.64 / $19.28	$12.36	$13.14	$15.46
Three-Tier									
Single	$5.66 / $6.18	$5.96 / $6.66	$6.74 / $7.40	$5.10 / $5.58	$5.34 / $5.86	$6.20 / $6.76	$4.38	$4.66	$5.48
Two Person	$10.78 / $11.76	$11.36 / $12.68	$12.84 / $14.10	$9.72 / $10.62	$10.18 / $11.16	$11.80 / $12.88	$8.26	$8.80	$10.34
Family	$15.10 / $16.42	$15.90 / $17.74	$17.96 / $19.74	$13.62 / $14.86	$14.26 / $15.62	$16.50 / $18.04	$11.54	$12.28	$14.44
Two-Tier									
Single	$5.66 / $6.18	$5.96 / $6.66	$6.74 / $7.40	$5.10 / $5.58	$5.34 / $5.86	$6.20 / $6.76	$4.38	$4.66	$5.48
Family	$14.48 / $15.76	$15.28 / $17.02	$17.22 / $18.94	$13.06 / $14.26	$13.68 / $14.98	$15.82 / $17.30	$11.10	$11.80	$13.88

These monthly rates are effective January 1, 2020, through December 31, 2020, and are subject to Iowa Insurance Division approval and Delta Dental's underwriting guidelines. Contributory plans require 50 percent participation. Adult coverage is 21 and older. Child coverage is up to age 21 as of the group's effective/renewal date. For per-person dental rates, after paying to insure three children up to the age of 21, Delta Dental will not charge for additional children (up to the age of 21) included on the policy.

DeltaVision is underwritten by Veratrus Benefit Solutions, Inc., a wholly owned subsidiary of Delta Dental of Iowa, utilizing the EyeMed Vision Care Insight network.

DELTA DENTAL®

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2460-F10183 09/2019