

Rates are guaranteed for two years for new groups.\*

# 2022 Dental and Vision Rates

## ▶ Employer Choice PPO plus Premier Prime Dental Plans

	# of Eligible EEs**	Per-Person Rates			Four-Tier Rates					
		Adult	Child	Child w/ Ortho	Single	Emp./Spouse	Emp./Child(ren)	Family	Emp./Child(ren) w/ Ortho	Family w/ Ortho
<b>A</b> Prime Plan A	Base Rate/1-9	\$25.82	\$16.04	\$18.34	\$24.22	\$50.52	\$44.76	\$71.92	\$53.68	\$84.38
	10-50	\$22.90	\$14.24	\$16.30	\$22.42	\$47.74	\$42.36	\$68.04	\$50.78	\$79.78
<b>B</b> Prime Plan B	Base Rate/1-9	\$33.44	\$21.60	\$25.30	\$32.42	\$69.50	\$61.70	\$99.38	\$76.10	\$119.54
	10-50	\$29.72	\$19.18	\$22.48	\$29.72	\$63.70	\$56.54	\$91.04	\$69.74	\$109.52
<b>C</b> Prime Plan C	Base Rate/1-9	\$29.04	\$22.94	\$27.08	\$28.16	\$60.90	\$54.04	\$87.32	\$66.84	\$105.22
	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

	# of Eligible EEs**	Per-Person Rates			Four-Tier Rates					
		Adult	Child	Child w/ Ortho	Single	Emp./Spouse	Emp./Child(ren)	Family	Emp./Child(ren) w/ Ortho	Family w/ Ortho
<b>A</b> Prime Plan A	Base Rate/1-9	\$29.44	\$19.12	\$20.82	\$28.26	\$60.14	\$53.26	\$85.58	\$63.88	\$100.44
	10-50	\$27.26	\$17.30	\$18.88	\$27.26	\$58.00	\$51.40	\$82.54	\$61.62	\$96.86
<b>B</b> Prime Plan B	Base Rate/1-9	\$43.76	\$30.54	\$34.24	\$41.62	\$84.72	\$75.60	\$119.36	\$92.40	\$142.84
	10-50	\$39.64	\$27.66	\$31.04	\$39.64	\$80.68	\$72.02	\$113.70	\$88.00	\$136.08
<b>C</b> Prime Plan C	Base Rate/1-9	\$37.66	\$26.32	\$30.44	\$35.82	\$74.26	\$66.20	\$105.26	\$81.26	\$126.34
	10-50	\$34.14	\$23.82	\$27.56	\$34.14	\$70.76	\$63.06	\$100.28	\$77.40	\$120.34

## ▶ Employer Choice Plus\*\*\* Dental Plans

	# of Eligible EEs**	Per-Person Rates				# of Eligible EEs**	Per-Person Rates		
		Adult	Child	Child w/ Ortho			Adult	Child	Child w/ Ortho
<b>B+</b> PPO plus Premier Plan B Plus	Base Rate/1-9	\$35.12	\$26.60	\$28.14	<b>B+</b> Premier Plan B Plus	Base Rate/1-9	\$43.04	\$31.62	\$33.24
	10-50	\$31.20	\$25.76	\$27.24		10-50	\$39.38	\$31.24	\$32.82

\*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), rates are based on the number of eligible employees. For all other groups, the base rate applies.

\*\*\*Employer Choice Plus Plans include the Affordable Care Act (ACA) pediatric dental essential health benefits (EHB).

## ► Employee Choice Dental Plan

Plan	Adult (21 and older)	Child (up to age 21)
Preventive Prime	\$16.18	\$15.66
Preventive Plus	\$16.18	\$31.52
Preferred Prime	\$32.08	\$24.60
Preferred Plus	\$32.08	\$37.58
Platinum Prime	\$40.08	\$30.72
Platinum Plus	\$40.08	\$37.58

## ► Voluntary Vision Plans

	\$10 Lens Copay			\$25 Lens Copay			Materials Only		
	\$130	\$150	\$200	\$130	\$150	\$200	\$130	\$150	\$200
Frame Allowance									
Fit & Follow-Up	Discounted / Funded	Discounted / Funded	Discounted / Funded	Discounted / Funded	Discounted / Funded	Discounted / Funded			
<b>Four-Tier</b>									
Single	\$7.58 / \$8.26	\$7.98 / \$8.90	\$9.02 / \$9.90	\$6.82 / \$7.48	\$7.14 / \$7.84	\$8.28 / \$9.04	\$5.86	\$6.22	\$7.32
Employee/Spouse	\$14.40 / \$15.74	\$15.18 / \$16.96	\$17.16 / \$18.86	\$13.00 / \$14.20	\$13.62 / \$14.92	\$15.78 / \$17.22	\$11.04	\$11.78	\$13.84
Employee/Child(ren)	\$16.34 / \$17.76	\$17.22 / \$19.20	\$19.44 / \$21.36	\$14.74 / \$16.10	\$15.42 / \$16.90	\$17.86 / \$19.52	\$12.56	\$13.34	\$15.70
Family	\$21.56 / \$23.46	\$22.76 / \$25.34	\$25.66 / \$28.20	\$19.46 / \$21.26	\$20.36 / \$22.32	\$23.58 / \$25.78	\$16.52	\$17.56	\$20.68
<b>Three-Tier</b>									
Single	\$7.58 / \$8.26	\$7.98 / \$8.90	\$9.02 / \$9.90	\$6.82 / \$7.48	\$7.14 / \$7.84	\$8.28 / \$9.04	\$5.86	\$6.22	\$7.32
Two Person	\$14.40 / \$15.74	\$15.18 / \$16.96	\$17.16 / \$18.86	\$13.00 / \$14.20	\$13.62 / \$14.92	\$15.78 / \$17.22	\$11.04	\$11.78	\$13.84
Family	\$20.18 / \$21.96	\$21.26 / \$23.74	\$24.00 / \$26.38	\$18.20 / \$19.88	\$19.06 / \$20.88	\$22.06 / \$24.12	\$15.42	\$16.44	\$19.32
<b>Two-Tier</b>									
Single	\$7.58 / \$8.26	\$7.98 / \$8.90	\$9.02 / \$9.90	\$6.82 / \$7.48	\$7.14 / \$7.84	\$8.28 / \$9.04	\$5.86	\$6.22	\$7.32
Family	\$19.34 / \$21.06	\$20.40 / \$22.74	\$23.04 / \$25.30	\$17.46 / \$19.08	\$18.26 / \$20.04	\$21.16 / \$23.12	\$14.84	\$15.78	\$18.54

## ► Contributory Vision Plans

	\$10 Lens Copay			\$25 Lens Copay			Materials Only		
	\$130	\$150	\$200	\$130	\$150	\$200	\$130	\$150	\$200
Frame Allowance									
Fit & Follow-Up	Discounted / Funded	Discounted / Funded	Discounted / Funded	Discounted / Funded	Discounted / Funded	Discounted / Funded			
<b>Four-Tier</b>									
Single	\$5.78 / \$6.30	\$6.08 / \$6.80	\$6.88 / \$7.56	\$5.20 / \$5.70	\$5.46 / \$5.98	\$6.32 / \$6.90	\$4.48	\$4.76	\$5.60
Employee/Spouse	\$11.00 / \$12.00	\$11.60 / \$12.94	\$13.10 / \$14.38	\$9.92 / \$10.84	\$10.38 / \$11.38	\$12.04 / \$13.14	\$8.44	\$8.98	\$10.56
Employee/Child(ren)	\$12.46 / \$13.56	\$13.14 / \$14.66	\$14.84 / \$16.30	\$11.24 / \$12.28	\$11.78 / \$12.90	\$13.64 / \$14.90	\$9.58	\$10.18	\$11.98
Family	\$16.46 / \$17.92	\$17.36 / \$19.34	\$19.58 / \$21.52	\$14.86 / \$16.22	\$15.54 / \$17.04	\$18.00 / \$19.68	\$12.62	\$13.40	\$15.78
<b>Three-Tier</b>									
Single	\$5.78 / \$6.30	\$6.08 / \$6.80	\$6.88 / \$7.56	\$5.20 / \$5.70	\$5.46 / \$5.98	\$6.32 / \$6.90	\$4.48	\$4.76	\$5.60
Two Person	\$11.00 / \$12.00	\$11.60 / \$12.94	\$13.10 / \$14.38	\$9.92 / \$10.84	\$10.38 / \$11.38	\$12.04 / \$13.14	\$8.44	\$8.98	\$10.56
Family	\$15.40 / \$16.76	\$16.22 / \$18.10	\$18.32 / \$20.14	\$13.90 / \$15.16	\$14.56 / \$15.94	\$16.84 / \$18.40	\$11.78	\$12.54	\$14.74
<b>Two-Tier</b>									
Single	\$5.78 / \$6.30	\$6.08 / \$6.80	\$6.88 / \$7.56	\$5.20 / \$5.70	\$5.46 / \$5.98	\$6.32 / \$6.90	\$4.48	\$4.76	\$5.60
Family	\$14.78 / \$16.08	\$15.60 / \$17.36	\$17.56 / \$19.32	\$13.32 / \$14.56	\$13.96 / \$15.28	\$16.14 / \$17.66	\$11.32	\$12.04	\$14.16

Enroll today ► Call **877-423-3582** or visit [deltadentalia.com](http://deltadentalia.com)



These monthly rates are effective January 1, 2022, through December 31, 2022, and are subject to Iowa Insurance Division approval. For new groups, rates are good for 24 months from initial enrollment as long as your plan does not change. Contributory plans are subject to underwriting guidelines and require the employer to contribute any amount towards premiums. 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 Veratus Benefit Solutions, Inc., a wholly owned subsidiary of Delta Dental of Iowa, utilizing the EyeMed Vision Care Insight network.