DELTA DENTAL

Delta Dental of Iowa
Renewal Financial Exhibit

Employer: CITY OF EARLHAM
Contact Name: MARY SUE HIBBS
Contact Email: EARLHAMCITYHALL@MCHSI.COM
Contract Period: Dec 1 2023 to Nov 30 2024

Group Number: 1-30903-1

Representative: HOLMES MURPHY & ASSOCIATES

CURRENT BENEFIT PLAN

Plan Code *PREMIER PLAN B PRIME	Delta Dental Premier®	Non Par
Annual Deductible:		
Per Person	$25	$50
Per Family		
Deductible Applies to Diagnostic and Preventive	No	Yes
Coinsurance Paid by Delta:		
Diagnostic and Preventive	100%	80%
Basic	80%	60%
Posterior Composites	50%	40%
Endodontics	50%	40%
Periodontics	50%	40%
Major Restorative	50%	40%
Prosthetic Repairs and Adjustments	50%	40%
Prosthetics	50%	40%
Annual Benefit Maximum Per Person	$2,000	$2,000
Annual Maximum Carryover - To Go SM		

*This is a summary of your benefits. Please see your Benefit Certificate for a full description of benefits.

MONTHLY DELTA DENTAL RATES

	Current	Renewal	Contracts
Single	$41.62	$43.08	5
Emp/Spouse	$84.72	$87.70	2
Emp/Child(ren)	$75.60	$78.26	0
Family	$119.36	$123.54	0

Changing Benefit Plan?

If you would like to change your plan, please indicate the new plan code/name:_____

After receiving your request for changes, an updated Financial Exhibit will be provided.

E-mail: TeamReNEW@deltadentalia.com
Fax: 888-337-5157
Phone: 877-423-3582, ext. 5

Important Message: Eligibility and contribution information impacts your rates. This form must be signed, completed and returned.

Percent of Premium Contributed by Employer: Single: _____ Family: _____ Total Employees Eligible for Dental Benefits: _____

Total Eligible Employees with Coverage Elsewhere: _____ Name and Email address for Billing Contact: _____

Name and Email address for Group Administrator: _____ Group Administrator Signature: _____ Date: _____