Delta Dental of Iowa
Renewal Financial Exhibit

Employer: IA COALITION AGAINST DOMESTIC
Contact Name: Maria Corona
Contact Email: director@icadv.org
Contract Period: Jan 1 2027 to Dec 31 2027

Group Number: 1-30261-1
Representative: KHI Solutions, LLC

CURRENT BENEFIT PLAN

Plan Code *PREMIER PLAN A 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	80%	60%
Basic	50%	40%
Posterior Composites	40%	30%
Endodontics	50%	40%
Periodontics	50%	40%
Major Restorative	50%	40%
Prosthetic Repairs and Adjustments	50%	40%
Prosthetics	50%	40%
Annual Benefit Maximum Per Person	$1,500	$1,500
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	$32.30	$33.44	9
Emp/Spouse	$68.66	$71.06	0
Emp/Child(ren)	$60.82	$62.96	0
Family	$97.74	$101.16	1

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: _____