DELTA DENTAL®

City of Dodgeville

Prepared by
Internal Community Users
Quote Number 00134587
Valid through 01/30/2025

Quote Number00134587

RATING ASSUMPTIONS	
Employer Contribution (Single/Family)	0-25%/0-25%
Broker Commission	8%

MONTHLY PREMIUMS	Without Delta Dental Plan	With Delta Dental Plan
TWO-TIER		
Employee	$7.18	$6.97
Family	$17.88	$17.36
THREE-TIER		
Employee	$7.18	$6.97
Employee + One Dependent	$13.68	$13.28
Employee + Two or More Dependents	$21.46	$20.83
FOUR-TIER		
Employee	$7.18	$6.97
Employee + Spouse	$14.36	$13.94
Employee + Child(ren)	$14.66	$14.23
Employee + Spouse + Child(ren)	$21.84	$21.20

This is not a complete description of benefits, exclusions, or limitations.This proposal is not a guarantee of coverage. A group application is required. Rates subject to change based on actual employer contribution, participation, plan selection and approval by Delta Dental of Wisconsin Underwriting. Final rates are guaranteed for 48 months from the effective date of coverage unless otherwise specified.