

TRI-COUNTY SCHOOLS INSURANCE GROUP

Delta Dental **PREMIER** Plan Rates (Monthly)

Effective: July 1, 2011

PREMIER PLAN:				
	D-1 No Orthodontic Coverage	D-2 Child Only Ortho Coverage	D-3 Adult & Child Ortho Coverage	D-4 Child Only Ortho & 70% Prosth
COMPOSITE:	\$83	\$86	\$87	\$92
TIERED:				
Employee Only	\$42	\$42	\$44	\$49
Employee + One Dependent	\$78	\$81	\$82	\$87
Employee + Family	\$113	\$116	\$118	\$124

ADD-ON COSTS: (by employee group only)						
	A D1, D2, D3 \$1,750 Annual Max	B D1, D2, D3 \$2,250 Annual Max	A D4 \$1,750 Annual Max	B D4 \$2,250 Annual Max	Child Only Ortho To \$1,000 D2, D4	Adult & Child Ortho To \$1,000 D3
COMPOSITE:	\$10.00	\$15.50	\$11.00	\$17.00	\$2	\$3
TIERED:						
Employee Only	\$5.00	\$8.00	\$6.00	\$9.00	\$2	\$3
Employee + One Dependent	\$9.50	\$14.50	\$10.50	\$16.00	\$2	\$3
Employee + Family	\$13.50	\$21.00	\$15.00	\$23.00	\$2	\$3