

# Delta Dental Benefit & Premium Rates

Participants may enroll within 31 days from a start/benefit eligibility date or life changing event.

This benefit does not include all exclusions or limitations to the policies. Marshfield Clinic Health System, individually or together with its insurers, reserves the right to revise, supplement, or rescind the policies and benefits described herein from time to time as it deems appropriate, in its sole and absolute discretion. Employees will be notified of changes to the policies or benefits through email and on-line publications.

## Delta Dental Plan

<b>Choice of dentists:</b> May choose any dentist. Reimbursement subject to Delta Dental's Maximum Plan Allowance. ( <a href="http://www.deltadentalwi.com">www.deltadentalwi.com</a> , then select Delta Dental PPO or Premier)			
<b>Deductible:</b> Single \$40/plan year    Family \$120/plan year Note: Deductible not applicable to diagnostic or preventive services.			
<b>Annual maximum:</b> \$1,500/plan year (per person) (Does not include orthodontia)			
<b>Diagnostic/preventive   Covered at 100%</b>			
Dental X-rays	Oral exams and cleanings	Fluoride application	Space maintainers
<b>Regular restorative   Covered at 80%</b>			
Emergency treatment for pain	Amalgam/composite restorations	Stainless steel crowns	Endodontics (root canals) Periodontics
<b>Special restorative   Covered at 80%</b>			
Inlays	Onlays	Jackets	Crowns
<b>Prosthetics   Covered at 80%</b>			
Bridges	Partials	Dentures	Repairs/adjustment
<b>Orthodontics</b>			
Appliances/treatment (no age limit, available to children and adults) Insurance pays 80% of cost up to a \$2,000 lifetime limit. Remaining cost is the responsibility of the patient.			
<b>Fluoride Application</b>			
100% coverage for fluoride application through Delta Dental is only covered as a preventive benefit up to age 19			

## Premium Rates (Level 1) 30+ Hours/week

Plan year: April 1, 2024 – March 31, 2025

Dental Insurance	Employee		Employer Monthly Cost	Total Monthly Cost
	Per Pay Period	Monthly Cost		
<b>Delta Dental Plan</b>				
Single	6.68	13.36	24.80	38.16
Employee +1	13.35	26.70	49.62	76.32
Employee + Children	16.21	32.42	60.19	92.61
Family	25.07	50.14	93.14	143.28

## Premium Rates (Level 2) 20 – 29.9 Hours/week

Plan year: April 1, 2024 – March 31, 2025

Dental Insurance	Employee		Employer Monthly Cost	Total Monthly Cost
	Per Pay Period	Monthly Cost		
<b>Delta Dental Plan</b>				
Single	10.26	20.52	17.64	38.16
Employee +1	20.53	41.06	35.26	76.32
Employee + Children	24.91	49.82	42.79	92.61
Family	38.54	77.08	66.20	143.28



**Marshfield Clinic  
Health System**