2017/2018 IAM Dental and Vision Plan Design Options

Dental Plan Options (Delta Dental of KS)	**Premier Plan**	**Standard Plan (PPO Plan)**	**Basic Plus Plan**
Annual Deductible • Single • Family	$25 $75	N/A	$50 $150
Preventive Services	100%	100%	100%
Annual Maximum Per Person	$1,500	N/A (some restrictions)	$1,000
Basic Services	80%	100%	50%
Major Services	50%	100%	50%
Orthodontia Services	50%	50%	No Benefit
Orthodontia Lifetime Maximum	$1,750	$1,750	N/A

Vision Plan Options (EyeMed)	**Enhanced**	**Basic**	**Exam Only**
Eye Exam Copay (Limited to one time per year)	$20	$20	$10
Lenses Benefit (Limited to once every 12 months)	0% Coinsurance	0% Coinsurance	0% (Limited Benefit – Standard Lenses)
Frames or Contacts in lieu of lenses/frames • Frame Allowance • Contact Allowance (Conventional or Disposable)	(Limited to once every 12 months) $210 $210	(Limited to once every 24 months) $135 $135	(N/A) Discounted Discounted

2017/2018 IAM Premium Rates (per pay period)

Medical Plan Options	Yellow PCP req.	Green	Blue	Orange	Core PCP req.	Enhanced
Employee	$36.82	$25.64	$5.42	($16.67)	$62.53	$15.46
Employee + Spouse OR Employee + Child(ren)	$73.64	$51.28	$10.84	($33.35)	$125.06	$30.91
Family	$110.45	$76.91	$16.26	($50.03)	$187.59	$46.37

Dental Plan Options	Premier	Standard (PPO plan)	Basic Plus
Employee Only	$1.85	$5.97	$0
Employee + Spouse OR Employee + Child(ren)	$3.71	$11.93	$0
Family	$5.56	$17.90	$0

Vision Plan Options	Enhanced	Basic	Exam Only
Employee Only	$2.98	$0.59	$0
Employee + Spouse OR Employee + Child(ren)	$5.96	$1.17	$0
Family	$8.94	$1.76	$0