

**Delta Dental  
Plan Premiums  
Effective: July 1, 2026**

<b>Plan Type</b>	<b>Coverage Level</b>	<b>Monthly Cost*</b>
<b>Delta Dental High Plan</b>	Employee Only	\$ 47.65
	Employee & One Dependent	\$ 89.39
	Family	\$ 141.28
<b>Delta Dental Low Plan</b>	Employee Only	\$ 32.17
	Employee & One Dependent	\$ 61.80
	Family	\$ 115.78

*\* Deducted 2nd paycheck of each month*

**Vision Benefits of America (VBA)**  
**Plan Premiums**  
**Effective: July 1, 2026**

Plan Type	Coverage	Monthly Cost*
<b>Annual Eye Exams/Glasses/Contacts</b>	Employee Only	\$ -
	Employee & Child(ren)	\$ 3.88
	Employee & Spouse	\$ 3.77
	Family	\$ 7.80

*\* deduced first paycheck of each month*