

Delta Dental

Carrier Plan:	
Network:	
Calendar Decuctible:	
Individual Annual Deductible	\$50
Family Annual Deductible	\$150
Preventive Service Coverage	100%
Basic Service Coverage	80%
Major Service Coverage	60%
Annual Benefit Maximum	\$2,000
Office Visit	None
Child Orthodontia Service	60%
Orthodontia Lifetime Max	\$2,000
Rates:	
Employee Only	\$2.70
Employee + Spouse	\$22.00
Employee + Child(ren)	\$29.00
Employee + Family	\$40.00

Delta Dental		
	PPO and Premier	Out of Network
Individual Annual Deductible	\$50	
Family Annual Deductible	\$150	
Preventive Service Coverage	100%	100%
Basic Service Coverage	80%	80%
Major Service Coverage	60%	60%
Annual Benefit Maximum	\$2,000	\$2,000
Office Visit	None	None
Child Orthodontia Service	60%	60%
Orthodontia Lifetime Max	\$2,000	\$2,000
Employee Only	\$2.70	
Employee + Spouse	\$22.00	
Employee + Child(ren)	\$29.00	
Employee + Family	\$40.00	

MetLife Vision

Rates:	
Employee Only	\$3.77
Employee + Spouse	\$7.56
Employee + Child(ren)	\$7.09
Employee + Family	\$10.86