Delta Dental and VSP

Insurance Plans July 1, 2024- June 30, 2025

Option to change plans will be each May to be effective the following July 1st

Open enrollment to add dependents will be each November to be effective the following January 1st

Plan A Delta Dental Group #1400		Employee Share Per Month	District Share Per Month	Total Premium Per Month
Deductible $50 per person $100 Family	Single	$3.49	$33.49	$36.95
	Emp + Spouse	$10.27	$63.88	$74.15
	Emp + Dependents	$14.72	$91.43	$106.15
	Family	$18.36	$114.14	$132.50
	2 Employee	District pays 100% for Emp +Sp or Family		

100% Coverage for Diagnostic and Prevenative Services-not subject to deductible. 80% Coverage for Basic Services. 70% Coverage for Major Services. Yearly Max $1200 Ortho Lifetime Max $1000

Plan B Delta Dental Group #1401		Employee Share Per Month	District Share Per Month	Total Premium Per Month
Deductible $75 per person $150 Family	Single	$1.90	$28.30	$30.20
	Emp + Spouse	$6.20	$54.50	$60.70
	Emp + Dependents	$10.14	$89.01	$99.15
	Family	$11.81	$103.64	$115.45
	2 Employee	District pays 100% for Emp +Sp or Family		

100% Coverage for Diagnostic and Prevenative Services-not subject to deductible. 50% Coverage for Basic Services. 50% Coverage for Major Services. Yearly Max $1200 Ortho Lifetime Max $1000

VSP Voluntary Vision		Employee Share Per Month	District Share Per Month	Total Premium Per Month
Well vision Exam $10 Co-Pay	Single	$10.58	$0.00	$10.58
	Emp + Spouse	$14.90	$0.00	$14.90
	Emp + Dependents	$14.90	$0.00	$14.90
	Family	$26.72	$0.00	$26.72

In Network Providers$160 Frame Allowance every 24 months, $140 Contact allowance every 12 months