DELTA DENTAL

# *IBEW Local 369*
# *Rate Sheet*

## *Rates for effective dates of 11-1-2017 through 10-1-2018*

### Monthly Premium
*(Bank Draft or Credit Card)*

| Contract Type | Delta Dental PPO Plus VSP Vision Monthly Premium | Delta Dental PPO Only Monthly Premium | VSP Vision Plan Only Monthly Premium |
|---|---|---|---|
| Employee only | $29.40 | $24.94 | $9.24 |
| Employee plus Spouse | $65.78 | $56.88 | $9.24 |
| Employee plus Child(ren) | $57.42 | $47.90 | $9.24 |
| Family | $90.06 | $80.82 | $9.24 |

### Annual Premium
*(Check, Money Order, or Credit Card)*

| Contract Type | Delta Dental PPO Plus VSP Vision Annual Premium | Delta Dental PPO Only Annual Premium | VSP Vision Plan Only Annual Premium |
|---|---|---|---|
| Employee only | $352.80 | $299.28 | $110.88 |
| Employee plus Spouse | $789.36 | $682.56 | $110.88 |
| Employee plus Child(ren) | $689.04 | $574.80 | $110.88 |
| Family | $1,080.72 | $969.84 | $110.88 |

*Applications received by the end of the month will be effective the first of the following month.*