January 1, 2027 - December 31, 2027
Dental Plan

$25 deductible per person - $75.00 deductable maximum per family
Dental Calendar Year Maximum Benefit - $1000 per person

		Monthly Contribution		Per Paycheck (24)		Annual	
Coverage (24 Pay)	**Cost**	**Board**	**Employee**	**Board**	**Employee**	**Board**	**Employee**
Single	$38.12	$30.50	$7.62	$15.25	$3.81	$365.95	$91.49
Family	$103.99	$83.19	$20.80	$41.60	$10.40	$998.30	$249.58
		Monthly Contribution		**Per Paycheck (18)**		**Annual**	
Coverage (18 Pay)	**Cost**	**Board**	**Employee**	**Board**	**Employee**	**Board**	**Employee**
Single	$50.83	$40.66	$10.17	$20.33	$5.08	$365.95	$91.49
Family	$138.65	$110.92	$27.73	$55.46	$13.87	$998.30	$249.58

January 1, 2027 - December 31, 2027
Vision Plan

Examination copay - $10
Material copay - $25
Lenses copay - $25
Frames copay - $0; $130 allowance; 20% of balance over $130
Benefit frequency: Examination 12 months, lenses/contacts 12 months, frames 24 months

		Monthly Contribution		Per Paycheck (24)		Annual	
Coverage (24 Pay)	**Cost**	**Board**	**Employee**	**Board**	**Employee**	**Board**	**Employee**
Single	$5.33	$4.26	$1.07	$2.13	$0.53	$51.17	$12.79
Single + Spouse	$10.13	$8.10	$2.03	$4.05	$1.01	$97.25	$24.31
Single + Child(ren)	$10.66	$8.53	$2.13	$4.26	$1.07	$102.34	$25.58
Family	$15.68	$12.54	$3.14	$6.27	$1.57	$150.53	$37.63
		Monthly Contribution		**Per Paycheck (18)**		**Annual**	
Coverage (18 Pay)	**Cost**	**Board**	**Employee**	**Board**	**Employee**	**Board**	**Employee**
Single	$7.11	$5.69	$1.42	$2.84	$0.71	$51.17	$12.79
Single + Spouse	$13.51	$10.81	$2.70	$5.40	$1.35	$97.25	$24.31
Single + Child(ren)	$14.21	$11.37	$2.84	$5.69	$1.42	$102.34	$25.58
Family	$20.91	$16.73	$4.18	$8.36	$2.09	$150.53	$37.63