

**DELTA DENTAL PLAN OF VIRGINIA  
DENTAL INSURANCE - EFFECTIVE OCTOBER 1, 2024**

**BASIC PLAN**

<u>TYPE OF COVERAGE</u>	<u>MONTHLY PREMIUM</u>	<u>COUNTY CONTRIBUTION</u>	<u>EMPLOYEE COST</u>	
			<u>MONTHLY*</u>	<u>SEMI. MO.</u>
Employee	20.28	12.00	8.28	4.14
Employee/Spouse	39.77	12.00	27.78	13.89
Employee/One Child	33.62	12.00	21.62	10.81
Family	66.58	12.00	54.58	27.29

**COMPREHENSIVE PLAN**

<u>TYPE OF COVERAGE</u>	<u>MONTHLY PREMIUM</u>	<u>COUNTY CONTRIBUTION</u>	<u>EMPLOYEE COST</u>	
			<u>MONTHLY*</u>	<u>SEMI. MO.</u>
Employee	30.99	12.00	19.00	9.50
Employee/Spouse	60.77	12.00	48.78	24.39
Employee/One Child	51.38	12.00	39.38	19.69
Family	101.74	12.00	89.74	44.87

*\*Amounts adjusted for cents*