Dental Plan Name ***Carrier***	Voluntary Dental Principal	
Deductible (Ind/Family)	$50/$150	
Preventative/Minor/Major	100/80/50%	
Annual Maximum	$1,500.00	
Network	Diversified+Principal	
	Monthly	Bi-weekly
Employee Only	$35.68	$16.47
Employee + Spouse	$77.05	$35.56
Employee + Child(ren)	$83.81	$38.68
Employee + Family	$130.95	$60.44

Vision Plan name **Carrier**	Voluntary Vision Principal (VSP)	
Exam	$10.00	
Frame Allowance How often	$150.00 12 Months	
Contact Lense Allowance How Often	$150.00 12 Months	
	Monthly Cost	Bi-weekly
Employee Only	$8.10	$3.74
Employee + Spouse	$17.40	$8.03
Employee + Child(ren)	$18.45	$8.52
Employee + Family	$29.81	$13.76