Johns Hopkins University

JHU Dental and Vision Plan - Public Health Voluntary

2026-2027 Final Premium Rates

	Term 1	Term 2	Term 3	Term 4	Annual
	8/15/2026 through 10/31/2026	11/1/2026 through 12/31/2026	1/1/2027 through 3/31/2027	4/1/2027 through 8/14/2027	8/15/2026 through 8/14/2027
Delta Dental					
Student*	$ 53.63	$ 42.90	$ 64.35	$ 96.53	$ 21.45
Dependent (+1)	$ 99.08	$ 79.26	$ 118.89	$ 178.34	$ 39.63
Family (2+)	$ 147.43	$ 117.94	$ 176.91	$ 265.37	$ 58.97
EyeMed Vision					
Student*					$ 59.00
Dependent (+1)					$ 59.00
Family (2+)					$ 59.00

*Dependent rates are inclusive of student only coverage.

** Students who are auto-enrolled in dental and/or vision will be billed for student only coverage via SIS (bursar) bill.