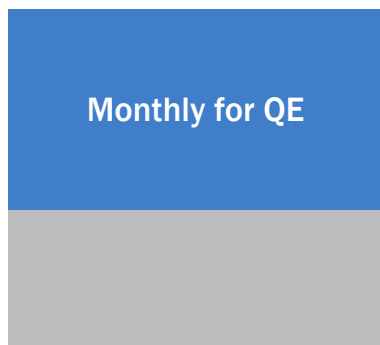


Johns Hopkins University

JHU Dental and Vision Plan - Voluntary

2026-2027 Final Premium Rates



Delta Dental		
Student*	\$	21.45
Dependent (+1)	\$	39.63
Family (2+)	\$	58.97

EyeMed Vision		
Student*	\$	5.00
Dependent (+1)	\$	5.00
Family (2+)	\$	5.00

*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.