Medical Policy # 0125981-0001-000 *Renewal Date:* 11/1/2022	Current Plan BCN HMO $500 100% (Current Billed Ages)		Renewal Plan - BCN HMO $500 100% (Renewal Billed Ages)		Platinum HAP HMO 500		Gold HAP HMO 1000	
Network:	BCN HMO		BCN HMO		HAP HMO		HAP HMO	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$500	N/A	$500	N/A	$500	N/A	**$1,000**	N/A
Family	$1,000	N/A	$1,000	N/A	$1,000	N/A	**$2,000**	N/A
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	100%	N/A	100%	N/A	100%	N/A	**80%**	N/A
Coinsurance Max - Single	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Coinsurance Max - Family	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$1,500	N/A	$1,500	N/A	**$2,000**	N/A	**$6,000**	N/A
Family	$3,000	N/A	$3,000	N/A	**$4,000**	N/A	**$12,000**	N/A
In-Network Employee Copay:								
Office Visit	$20		$20		$20		**$30**	
TeleMedicine Visit	$20		$20		$20		**$30**	
Specialist Visit	$30		$30		**$40**		**$60**	
Urgent Care	$35		$35		**$65**		**$65**	
Emergency Room	$150 after Deductible		$150 after Deductible		**$200**		**$300**	
Hospital Admission	0% after Deductible		0% after Deductible		0% after Deductible		**20% after Deductible**	
Imaging	$150 after Deductible		$150 after Deductible		**0% after Deductible**		**$150 Copay per Test**	
Employee In-Network RX Copay:								
Tier 1 / 1A: Generic	$4 or $15		$4 or $15		$5	$15	$5	**$25**
Tier 2: Preferred Brand	$40		$40		**$30**		$40	
Tier 3: Non-Preferred Brand	$80		$80		**$60**		$80	
Tier 4: Preferred Specialty	20% ($200 Maximum)		20% ($200 Maximum)		20% ($200 Maximum)		20% ($200 Maximum)	
Tier 5: Non-Preferred Specialty	20% ($300 Maximum)		20% ($300 Maximum)		**50% ($500 Maximum)**		**50% ($500 Maximum)**	
Prescription Formulary	**Custom Select**		**Custom Select**		**N/A**		**N/A**	
Plan Provisions:								
Dependent Age	End of Year Age 26		End of Year Age 26					
Pediatric Dental	Covered on Dental		Covered on Dental		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Included or Not Included		Included or Not Included		Included or Not Included	
Monthly / Annual Premium	**$20,912.74**	**$250,952.88**	**$23,216.21**	**$278,594.52**	**$24,905.29**	**$298,863.48**	**$19,527.70**	**$234,332.40**
$ Change from Current			$2,303.47	$27,641.64	$3,992.55	$47,910.60	($1,385.04)	($16,620.48)
% Change from Current			11.01%		19.09%		-6.62%	

Medical Policy # *0125981-0001-000* *Renewal Date:* *11/1/2022*	Current Plan BCN HMO $500 100% (Current Billed Ages)		Renewal Plan - BCN HMO $500 100% (Renewal Billed Ages)		Platinum United Healthcare CC-Z7		Platinum United Healthcare CN-AL	
Network:	BCN HMO		BCN HMO		UHC Choice HMO Premier PROformance		UHC Choice HMO Premier PROformance	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$500	N/A	$500	N/A	$500	N/A	**$1,000**	N/A
Family	$1,000	N/A	$1,000	N/A	$1,000	N/A	**$2,000**	N/A
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	100%	N/A	100%	N/A	100%	N/A	100%	N/A
Coinsurance Max - Single	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Coinsurance Max - Family	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$1,500	N/A	$1,500	N/A	**$6,000**	N/A	**$3,000**	N/A
Family	$3,000	N/A	$3,000	N/A	**$12,000**	N/A	**$6,000**	N/A
In-Network Employee Copay:								
Office Visit	$20		$20		**$15**		**$10**	
TeleMedicine Visit	$20		$20		**$15**		**$10**	
Specialist Visit	$30		$30		**$50 or $100**		**$40 or $80**	
Urgent Care	$35		$35		**$25**		**$25**	
Emergency Room	$150 after Deductible		$150 after Deductible		**$300 per Occurrence per visit ded,**		**$300 per Occurrence per visit ded,**	
Hospital Admission	0% after Deductible		0% after Deductible		0% after Deductible		0% after Deductible	
Imaging	$150 after Deductible		$150 after Deductible		**$500 per Occurrence Ded, then 50%**		**$500 per Occurrence Ded, then 50%**	
Employee In-Network RX Copay:								
Tier 1 / 1A: Generic	$4 or $15		$4 or $15		**$10**		**$10**	
Tier 2: Preferred Brand	$40		$40		$40		$40	
Tier 3: Non-Preferred Brand	$80		$80		**$105**		$105	
Tier 4: Preferred Specialty	20% ($200 Maximum)		20% ($200 Maximum)		**$250**		$250	
Tier 5: Non-Preferred Specialty	20% ($300 Maximum)		20% ($300 Maximum)		**$250**		**$250**	
Prescription Formulary	**Custom Select**		**Custom Select**		**N/A**		**N/A**	
Plan Provisions:								
Dependent Age	End of Year Age 26		End of Year Age 26					
Pediatric Dental	Covered on Dental		Covered on Dental		Included		Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Included or Not Included		Included or Not Included		Included or Not Included	
Monthly / Annual Premium	**$20,912.74**	**$250,952.88**	**$23,216.21**	**$278,594.52**	**$28,907.15**	**$346,885.80**	**$27,530.27**	**$330,363.24**
$ Change from Current			$2,303.47	$27,641.64	$7,994.41	$95,932.92	$6,617.53	$79,410.36
% Change from Current			11.01%		38.23%		31.64%	

Medical Policy # 0125981-0001-000 *Renewal Date:* 11/1/2022	Current Plan BCN HMO $500 100% (Current Billed Ages)		Renewal Plan - BCN HMO $500 100% (Renewal Billed Ages)		Gold Priority Health HMO 500		Gold Priority Health HMO 850	
Network:	BCN HMO		BCN HMO		Priority Health HMO		Priority Health HMO	
Employee Deductible:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$500	N/A	$500	N/A	$500	N/A	**$850**	N/A
Family	$1,000	N/A	$1,000	N/A	$1,000	N/A	**$1,700**	N/A
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Carrier Coinsurance Liability %	100%	N/A	100%	N/A	**80%**	N/A	**70%**	N/A
Coinsurance Max - Single	N/A	N/A	N/A	N/A	**$5,500**	N/A	**$5,000**	N/A
Coinsurance Max - Family	N/A	N/A	N/A	N/A	**$11,000**	N/A	**$10,000**	N/A
EE True Out of Pocket Max:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$1,500	N/A	$1,500	N/A	**$8,100**	N/A	$8,500	N/A
Family	$3,000	N/A	$3,000	N/A	**$16,200**	N/A	**$17,000**	N/A
In-Network Employee Copay:								
Office Visit	$20		$20		**$25**		**$15**	
TeleMedicine Visit	$20		$20		**$25**		**$15**	
Specialist Visit	$30		$30		**$50**		**$40**	
Urgent Care	$35		$35		**$85**		**$85**	
Emergency Room	$150 after Deductible		$150 after Deductible		**$250 after Deductible**		**$250 after Deductible**	
Hospital Admission	0% after Deductible		0% after Deductible		**20% after Deductible**		**30% after Deductible**	
Imaging	$150 after Deductible		$150 after Deductible		**$250 after Deductible**		**$250 after Deductible**	
Employee In-Network RX Copay:								
Tier 1 / 1A: Generic	$4 or $15		$4 or $15		$5	**$35**	$5	**$25**
Tier 2: Preferred Brand	$40		$40		**$75**		**$65**	
Tier 3: Non-Preferred Brand	$80		$80		**$95**		**$85**	
Tier 4: Preferred Specialty	20% ($200 Maximum)		20% ($200 Maximum)		**20% ($250 Maximum)**		**20% ($250 Maximum)**	
Tier 5: Non-Preferred Specialty	20% ($300 Maximum)		20% ($300 Maximum)		**20% ($450 Maximum)**		**20% ($450 Maximum)**	
Prescription Formulary	**Custom Select**		**Custom Select**		**N/A**		**N/A**	
Plan Provisions:								
Dependent Age	End of Year Age 26		End of Year Age 26					
Pediatric Dental	Covered on Dental		Covered on Dental		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Included or Not Included		Included or Not Included		Included or Not Included	
Monthly / Annual Premium	**$20,912.74**	**$250,952.88**	**$23,216.21**	**$278,594.52**	**$18,813.21**	**$225,758.52**	**$18,247.61**	**$218,971.32**
$ Change from Current			$2,303.47	$27,641.64	($2,099.53)	($25,194.36)	($2,665.13)	($31,981.56)
% Change from Current			11.01%		-10.04%		-12.74%	

		Current Delta Dental			Renewal Delta Dental			Reliance Standard	
Dental Policy #	**4544**								
Renewal Date:	***11/1/2022***								
Plan Provisions:		**Delta PPO**	**Premier**	**Non - Participatio**	**Delta PPO**	**Premier**	**Non - Participatio**	**In-Network**	**Out-of-Network**
Network / UCR		Delta Dental USA		Non-Participating Fee	Delta Dental USA		Non-Participating Fee	Ameritas	90th
Single Deductible		$50	$50	$50	$50	$50	$50	$50	$50
Two Person / Family Deductible		$150	$150	$150	$150	$150	$150	$150	$150
Calendar Year Max Per Person			$1,500			$1,500		$1,500	
Pediatric Dental EHB (Small Group Only)			Included in Rates			Included in Rates		Included in Rates	
Maximum Rollover			Not Included			Not Included		Not Included	
Preventative Advantage			Included			Included		**Not Included**	
Type I - Preventative Services:									
Cleanings (Oral Prophylaxis)		100%	100%	100%	100%	100%	100%	100%	100%
Frequency on Routine Cleanings		2x	2x	2x	2x	2x	2x	2x	2x
Exams		100%	100%	100%	100%	100%	100%	100%	100%
X-Rays		100%	100%	100%	100%	100%	100%	100%	100%
Fluoride Treatments		100%	100%	100%	100%	100%	100%	100%	100%
Type II - Basic Services:									
Fillings		80%	80%	80%	80%	80%	80%	80%	80%
Oral Surgery		80%	80%	80%	80%	80%	80%	80%	80%
Periodontics		80%	80%	80%	80%	80%	80%	80%	80%
Endodontics		80%	80%	80%	80%	80%	80%	80%	80%
Type III - Major Services:									
Crowns / Onlays		50%	50%	50%	50%	50%	50%	50%	50%
Bridges / Dentures		80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	**50%**	**50%**
Implants		80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	**Not Covered**	**Not Covered**
Type IV - Child Orthodontics:									
Orthodontics		N/A		N/A	N/A		N/A	N/A	N/A
Child Ortho Lifetime Max			N/A			N/A		N/A	
Additional Details:									
Participation Requirement			75% of all Eligible Employees			75% of all Eligible Employees		Greatre of 60% or 10 Lives	
Dependent Age			To End of Year Age 26			To End of Year Age 26		**To End of Month Age 26**	
Headcounts / Rates:									
Single	**20**		**$49.96**			**$49.96**		**$42.43**	
EE & Spouse	**3**		**$91.93**			**$91.93**		**$85.95**	
EE & Child	**2**		**$91.93**			**$91.93**		**$103.56**	
EE & Children	**1**		**$154.06**			**$154.06**		**$103.56**	
Family	**3**		**$154.06**			**$154.06**		**$147.08**	
Total Enrolled	**29**								
Rate Guarantee Duration:						12 Months		12 Months	
Monthly / Annual Premium		**$2,075.09**		**$24,901.08**	**$2,075.09**		**$24,901.08**	**$1,858.37**	**$22,300.44**
$ Change from Current					**$0.00**		**$0.00**	($216.72)	($2,600.64)
% Change from Current						**0.00%**		-10.44%	

		Current Delta Dental			Renewal Delta Dental			UNUM	
Dental Policy #	**4544**								
Renewal Date:	***11/1/2022***								
Plan Provisions:		**Delta PPO**	**Premier**	**Non - Participation**	**Delta PPO**	**Premier**	**Non - Participation**	**In-Network**	**Out-of-Network**
Network / UCR		Delta Dental USA		Non-Participating Fee	Delta Dental USA		Non-Participating Fee	DenteMax	90th
Single Deductible		$50	$50	$50	$50	$50	$50	$50	$50
Two Person / Family Deductible		$150	$150	$150	$150	$150	$150	$150	$150
Calendar Year Max Per Person			$1,500			$1,500		$1,500	
Pediatric Dental EHB (Small Group Only)			Included in Rates			Included in Rates		Included in Rates	
Maximum Rollover			Not Included			Not Included		**Included**	
Preventative Advantage			Included			Included		**Not Included**	
Type I - Preventative Services:									
Cleanings (Oral Prophylaxis)		100%	100%	100%	100%	100%	100%	100%	100%
Frequency on Routine Cleanings		2x	2x	2x	2x	2x	2x	2x	2x
Exams		100%	100%	100%	100%	100%	100%	100%	100%
X-Rays		100%	100%	100%	100%	100%	100%	100%	100%
Fluoride Treatments		100%	100%	100%	100%	100%	100%	100%	100%
Type II - Basic Services:									
Fillings		80%	80%	80%	80%	80%	80%	**90%**	**90%**
Oral Surgery		80%	80%	80%	80%	80%	80%	**90%**	**90%**
Periodontics		80%	80%	80%	80%	80%	80%	**90%**	**90%**
Endodontics		80%	80%	80%	80%	80%	80%	**90%**	**90%**
Type III - Major Services:									
Crowns / Onlays		50%	50%	50%	50%	50%	50%	**60%**	**60%**
Bridges / Dentures		80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	**60%**	**60%**
Implants		80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	**60%**	**60%**
Type IV - Child Orthodontics:									
Orthodontics		N/A		N/A	N/A		N/A	N/A	N/A
Child Ortho Lifetime Max			N/A			N/A		N/A	
Additional Details:									
Participation Requirement			75% of all Eligible Employees			75% of all Eligible Employees		Minimum 10 Enrolled	
Dependent Age			To End of Year Age 26			To End of Year Age 26		To End of Year Age 26	
Headcounts / Rates:									
Single	20		**$49.96**			**$49.96**		**$47.84**	
EE & Spouse	3		**$91.93**			**$91.93**		**$94.36**	
EE & Child	2		**$91.93**			**$91.93**		**$105.94**	
EE & Children	1		**$154.06**			**$154.06**		**$105.94**	
Family	3		**$154.06**			**$154.06**		**$163.26**	
Total Enrolled	29								
Rate Guarantee Duration:						12 Months		12 Months	
Monthly / Annual Premium		**$2,075.09**		**$24,901.08**	**$2,075.09**		**$24,901.08**	**$2,047.48**	**$24,569.76**
$ Change from Current					$0.00		$0.00	($27.61)	($331.32)
% Change from Current						0.00%		-1.33%	

		Current Delta Dental			Renewal Delta Dental			Guardian	
Dental Policy #	**4544**								
Renewal Date:	***11/1/2022***								
Plan Provisions:		**Delta PPO**	**Premier**	**Non - Participatio**	**Delta PPO**	**Premier**	**Non - Participatio**	**In-Network**	**Out-of-Network**
Network / UCR		Delta Dental USA		Non-Participating Fee	Delta Dental USA		Non-Participating Fee	DentalGuard Preferred	90th
Single Deductible		$50	$50	$50	$50	$50	$50	$50	$50
Two Person / Family Deductible		$150	$150	$150	$150	$150	$150	$150	$150
Calendar Year Max Per Person			$1,500			$1,500		$1,500	
Pediatric Dental EHB (Small Group Only)			Included in Rates			Included in Rates		Included in Rates	
Maximum Rollover			Not Included			Not Included		**Included**	
Preventative Advantage			Included			Included		Included	
Type I - Preventative Services:									
Cleanings (Oral Prophylaxis)		100%	100%	100%	100%	100%	100%	100%	100%
Frequency on Routine Cleanings		2x	2x	2x	2x	2x	2x	2x	2x
Exams		100%	100%	100%	100%	100%	100%	100%	100%
X-Rays		100%	100%	100%	100%	100%	100%	100%	100%
Fluoride Treatments		100%	100%	100%	100%	100%	100%	100%	100%
Type II - Basic Services:									
Fillings		80%	80%	80%	80%	80%	80%	80%	80%
Oral Surgery		80%	80%	80%	80%	80%	80%	80%	80%
Periodontics		80%	80%	80%	80%	80%	80%	80%	80%
Endodontics		80%	80%	80%	80%	80%	80%	80%	80%
Type III - Major Services:									
Crowns / Onlays		50%	50%	50%	50%	50%	50%	50%	50%
Bridges / Dentures		80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	50%	50%
Implants		80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	50%	50%
Type IV - Child Orthodontics:									
Orthodontics		N/A		N/A	N/A		N/A	N/A	N/A
Child Ortho Lifetime Max			N/A			N/A		N/A	
Additional Details:									
Participation Requirement			75% of all Eligible Employees			75% of all Eligible Employees		85% of Eligible Employees	
Dependent Age			To End of Year Age 26			To End of Year Age 26		To End of Year Age 26	
Headcounts / Rates:								*Sold with All Quoted Lines*	
Single	**20**		**$49.96**			**$49.96**		**$49.96**	
EE & Spouse	**3**		**$91.93**			**$91.93**		**$91.96**	
EE & Child	**2**		**$91.93**			**$91.93**		**$91.93**	
EE & Children	**1**		**$154.06**			**$154.06**		**$154.06**	
Family	**3**		**$154.06**			**$154.06**		**$154.06**	
Total Enrolled	**29**								
Rate Guarantee Duration:						12 Months		12 Months	
Monthly / Annual Premium		**$2,075.09**		**$24,901.08**	**$2,075.09**		**$24,901.08**	$2,075.18	$24,902.16
$ Change from Current					$0.00		$0.00	$0.09	$1.08
% Change from Current						0.00%			0.00%

		Current Delta Dental			Renewal Delta Dental			UNUM	
Dental Policy #	**4544**								
Renewal Date:	***11/1/2022***								
Plan Provisions:		**Delta PPO**	**Premier**	**Non - Participatio**	**Delta PPO**	**Premier**	**Non - Participatio**	**In-Network**	**Out-of-Network**
Network / UCR		Delta Dental USA		Non-Participating Fee	Delta Dental USA		Non-Participating Fee	DenteMax	90th
Single Deductible		$50	$50	$50	$50	$50	$50	$50	$50
Two Person / Family Deductible		$150	$150	$150	$150	$150	$150	$150	$150
Calendar Year Max Per Person			$1,500			$1,500		$1,500	
Pediatric Dental EHB (Small Group Only)			Included in Rates			Included in Rates		Included in Rates	
Maximum Rollover			Not Included			Not Included		**Included**	
Preventative Advantage			Included			Included		**Not Included**	
Type I - Preventative Services:									
Cleanings (Oral Prophylaxis)		100%	100%	100%	100%	100%	100%	100%	100%
Frequency on Routine Cleanings		2x	2x	2x	2x	2x	2x	2x	2x
Exams		100%	100%	100%	100%	100%	100%	100%	100%
X-Rays		100%	100%	100%	100%	100%	100%	100%	100%
Fluoride Treatments		100%	100%	100%	100%	100%	100%	100%	100%
Type II - Basic Services:									
Fillings		80%	80%	80%	80%	80%	80%	**90%**	**90%**
Oral Surgery		80%	80%	80%	80%	80%	80%	**90%**	**90%**
Periodontics		80%	80%	80%	80%	80%	80%	**90%**	**90%**
Endodontics		80%	80%	80%	80%	80%	80%	**90%**	**90%**
Type III - Major Services:									
Crowns / Onlays		50%	50%	50%	50%	50%	50%	**60%**	**60%**
Bridges / Dentures		80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	**60%**	**60%**
Implants		80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	**60%**	**60%**
Type IV - Child Orthodontics:									
Orthodontics		N/A		N/A	N/A		N/A	**50%**	**50%**
Child Ortho Lifetime Max			N/A			N/A		**$1,000**	
Additional Details:									
Participation Requirement			75% of all Eligible Employees			75% of all Eligible Employees		Minimum 10 Enrolled	
Dependent Age			To End of Year Age 26			To End of Year Age 26		To End of Year Age 26	
Headcounts / Rates:									
Single	**20**		**$49.96**			**$49.96**		**$47.84**	
EE & Spouse	**3**		**$91.93**			**$91.93**		**$94.36**	
EE & Child	**2**		**$91.93**			**$91.93**		**$111.58**	
EE & Children	**1**		**$154.06**			**$154.06**		**$111.58**	
Family	**3**		**$154.06**			**$154.06**		**$169.94**	
Total Enrolled	**29**								
Rate Guarantee Duration:						12 Months		12 Months	
Monthly / Annual Premium		**$2,075.09**		**$24,901.08**	**$2,075.09**		**$24,901.08**	$2,084.44	$25,013.28
$ Change from Current					$0.00		$0.00	$9.35	$112.20
% Change from Current						0.00%		0.45%	

Dental Policy # 4544 *Renewal Date:* 11/1/2022	Current Delta Dental			Renewal Delta Dental			Delta Dental		
Plan Provisions:	**Delta PPO**	**Premier**	**Non - Participatior**	**Delta PPO**	**Premier**	**Non - Participatior**	**Delta PPO**	**Premier**	**Nonparticipating**
Network / UCR	Delta Dental USA		Non-Participating Fee	Delta Dental USA		Non-Participating Fee	Delta Dental USA		Non-Participating Fee
Single Deductible	$50	$50	$50	$50	$50	$50	$50	$50	$50
Two Person / Family Deductible	$150	$150	$150	$150	$150	$150	$150	$150	$150
Calendar Year Max Per Person		$1,500			$1,500			**$2,000**	
Pediatric Dental EHB (Small Group Only)		Included in Rates			Included in Rates			Included in Rates	
Maximum Rollover		Not Included			Not Included			Not Included	
Preventative Advantage		Included			Included			Included	
Type I - Preventative Services:									
Cleanings (Oral Prophylaxis)	100%	100%	100%	100%	100%	100%	100%	100%	100%
Frequency on Routine Cleanings	2x	2x	2x	2x	2x	2x	2x	2x	2x
Exams	100%	100%	100%	100%	100%	100%	100%	100%	100%
X-Rays	100%	100%	100%	100%	100%	100%	100%	100%	100%
Fluoride Treatments	100%	100%	100%	100%	100%	100%	100%	100%	100%
Type II - Basic Services:									
Fillings	80%	80%	80%	80%	80%	80%	80%	80%	80%
Oral Surgery	80%	80%	80%	80%	80%	80%	80%	80%	80%
Periodontics	80%	80%	80%	80%	80%	80%	80%	80%	80%
Endodontics	80%	80%	80%	80%	80%	80%	80%	80%	80%
Type III - Major Services:									
Crowns / Onlays	50%	50%	50%	50%	50%	50%	50%	50%	50%
Bridges / Dentures	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%
Implants	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%
Type IV - Child Orthodontics:									
Orthodontics	N/A		N/A	N/A		N/A	N/A		N/A
Child Ortho Lifetime Max		N/A			N/A			N/A	
Additional Details:									
Participation Requirement	75% of all Eligible Employees			75% of all Eligible Employees			75% of all Eligible Employees		
Dependent Age	To End of Year Age 26			To End of Year Age 26			To End of Year Age 26		
Headcounts / Rates:									
Single 20		**$49.96**			**$49.96**			**$51.21**	
EE & Spouse 3		**$91.93**			**$91.93**			**$94.17**	
EE & Child 2		**$91.93**			**$91.93**			**$94.17**	
EE & Children 1		**$154.06**			**$154.06**			**$157.33**	
Family 3		**$154.06**			**$154.06**			**$157.33**	
Total Enrolled 29									
Rate Guarantee Duration:					12 Months				
Monthly / Annual Premium	**$2,075.09**		**$24,901.08**	**$2,075.09**		**$24,901.08**	**$2,124.37**		**$25,492.44**
$ Change from Current				$0.00		$0.00	$49.28		$591.36
% Change from Current					0.00%			2.37%	