

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)
Network:	BCN HMO	BCN HMO
Employee Deductible:	In-Network \$500 Out-of-Network N/A	In-Network \$500 Out-of-Network N/A
Coinsurance:	In-Network \$1,000 Out-of-Network N/A	In-Network \$1,000 Out-of-Network N/A
Carrier Coinsurance Liability %	100%	100%
Coinsurance Max - Single	N/A	N/A
Coinsurance Max - Family	N/A	N/A
EE True Out of Pocket Max:	In-Network \$1,500 Out-of-Network N/A	In-Network \$1,500 Out-of-Network N/A
In-Network Employee Copay:	In-Network \$3,000 Out-of-Network N/A	In-Network \$3,000 Out-of-Network N/A
Office Visit	\$20	\$20
TeleMedicine Visit	\$20	\$20
Specialist Visit	\$30	\$30
Urgent Care	\$35	\$35
Emergency Room	\$150 after Deductible	\$150 after Deductible
Hospital Admission	0% after Deductible	0% after Deductible
Imaging	\$150 after Deductible	\$150 after Deductible
Employee In-Network RX Copay:	\$4 or \$15	\$4 or \$15
Tier 1 / 1A: Generic	\$40	\$40
Tier 2: Preferred Brand	\$80	\$80
Tier 3: Non-Preferred Brand	20% (\$200 Maximum)	20% (\$200 Maximum)
Tier 4: Preferred Specialty	20% (\$300 Maximum)	20% (\$300 Maximum)
Tier 5: Non-Preferred Specialty	Custom Select	Custom Select
Prescription Formulary	End of Year Age 26	End of Year Age 26
Plan Provisions:	Covered on Dental	Covered on Dental
Dependent Age	Not Included	Not Included
Pediatric Dental	Not Included	Not Included
Elective Abortion	Not Included	Not Included
Domestic Partner Rider	Not Included	Not Included
Monthly / Annual Premium	\$20,912.74	\$250,952.88

\$ Change from Current \$23,216.21
% Change from Current 11.01%

	Platinum HAP HMO 500	Gold HAP HMO 1000
Network:	HAP HMO	HAP HMO
Employee Deductible:	In-Network \$500 Out-of-Network N/A	In-Network \$1,000 Out-of-Network N/A
Coinsurance:	In-Network \$1,000 Out-of-Network N/A	In-Network \$2,000 Out-of-Network N/A
Carrier Coinsurance Liability %	100%	80%
Coinsurance Max - Single	N/A	N/A
Coinsurance Max - Family	N/A	N/A
EE True Out of Pocket Max:	In-Network \$2,000 Out-of-Network N/A	In-Network \$6,000 Out-of-Network N/A
In-Network Employee Copay:	In-Network \$4,000 Out-of-Network N/A	In-Network \$12,000 Out-of-Network N/A
Office Visit	\$20	\$30
TeleMedicine Visit	\$20	\$30
Specialist Visit	\$40	\$60
Urgent Care	\$65	\$65
Emergency Room	\$200	\$300
Hospital Admission	0% after Deductible	20% after Deductible
Imaging	0% after Deductible	\$150 Copay per Test
Employee In-Network RX Copay:	\$5	\$5
Tier 1 / 1A: Generic	\$30	\$40
Tier 2: Preferred Brand	\$60	\$80
Tier 3: Non-Preferred Brand	20% (\$200 Maximum)	20% (\$200 Maximum)
Tier 4: Preferred Specialty	50% (\$500 Maximum)	50% (\$500 Maximum)
Tier 5: Non-Preferred Specialty	N/A	N/A
Prescription Formulary	Not Included	Not Included
Plan Provisions:	Not Included	Not Included
Dependent Age	Not Included	Not Included
Pediatric Dental	Not Included	Not Included
Elective Abortion	Not Included	Not Included
Domestic Partner Rider	Not Included	Not Included
Monthly / Annual Premium	\$24,905.29	\$19,527.70

\$ Change from Current \$298,863.48
% Change from Current 19.09%



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	JHC Choice HMO Premier Performance	JHC Choice HMO Premier Performance
Employee Deductible:	In-Network \$500 \$1,000	Out-of-Network N/A N/A	In-Network \$500 \$1,000	In-Network \$1,000 \$2,000
Coinsurance:	Out-of-Network 100% N/A N/A	Out-of-Network N/A N/A N/A	Out-of-Network 100% N/A N/A	Out-of-Network N/A N/A N/A
Carrier Coinsurance Liability %				
Coinsurance Max - Single	N/A	N/A	N/A	N/A
Coinsurance Max - Family	N/A	N/A	N/A	N/A
EE True Out of Pocket Max:	In-Network \$1,500 \$3,000	Out-of-Network N/A N/A	In-Network \$6,000 \$12,000	Out-of-Network N/A 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, 0% after Deductible	\$300 per Occurrence per visit ded, 0% after Deductible
Hospital Admission	0% after Deductible	0% after Deductible	\$500 per Occurrence Ded, then 50%	\$500 per Occurrence Ded, then 50%
Imaging	\$150 after Deductible	\$150 after Deductible		
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	Included	Included
Pediatric Dental	Covered on Dental	Covered on Dental	Not Included	Not Included
Elective Abortion	Not Included	Not Included	Included or Not Included	Included or Not Included
Domestic Partner Rider	Not Included	Included or Not Included		
Monthly / Annual Premium	\$20,912.74	\$250,952.88	\$28,907.15	\$27,530.27
<i>\$ Change from Current</i>	\$2,303.47	\$278,594.52	\$7,994.41	\$6,617.53
<i>% Change from Current</i>	11.01%	\$27,641.64	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)
Network:	BCN HMO	BCN HMO
Employee Deductible:	<u>In-Network</u> \$500 \$1,000	<u>In-Network</u> \$500 \$1,000
Coinsurance:	<u>Out-of-Network</u> N/A N/A	<u>Out-of-Network</u> N/A N/A
Carrier Coinsurance Liability %	100%	100%
Coinsurance Max - Single	N/A	N/A
Coinsurance Max - Family	N/A	N/A
EE True Out of Pocket Max:	<u>In-Network</u> \$1,500 \$3,000	<u>Out-of-Network</u> N/A N/A
In-Network Employee Copay:	<u>Out-of-Network</u> N/A N/A	<u>Out-of-Network</u> N/A N/A
Office Visit	\$20	\$20
TeleMedicine Visit	\$20	\$20
Specialist Visit	\$30	\$30
Urgent Care	\$35	\$35
Emergency Room	\$150 after Deductible	\$150 after Deductible
Hospital Admission	0% after Deductible	0% after Deductible
Imaging	\$150 after Deductible	\$150 after Deductible
Employee In-Network RX Copay:		
Tier 1 / 1A: Generic	\$4 or \$15	\$4 or \$15
Tier 2: Preferred Brand	\$40	\$40
Tier 3: Non-Preferred Brand	\$80	\$80
Tier 4: Preferred Specialty	20% (\$200 Maximum)	20% (\$200 Maximum)
Tier 5: Non-Preferred Specialty	20% (\$300 Maximum)	20% (\$300 Maximum)
Prescription Formulary	Custom Select	Custom Select
Plan Provisions:		
Dependent Age	End of Year Age 26	End of Year Age 26
Pediatric Dental	Covered on Dental	Covered on Dental
Elective Abortion	Not Included	Not Included
Domestic Partner Rider	Not Included	Included or Not Included
Monthly / Annual Premium	\$20,912.74	\$23,716.21
\$ Change from Current	\$250,952.88	\$278,594.52
% Change from Current		11.01%

	Gold Priority Health HMO 500	Gold Priority Health HMO 850
Network:	Priority Health HMO	Priority Health HMO
Employee Deductible:	<u>In-Network</u> \$500 \$1,000	<u>In-Network</u> \$850 \$1,700
Coinsurance:	<u>Out-of-Network</u> N/A N/A	<u>Out-of-Network</u> N/A N/A
Carrier Coinsurance Liability %	80%	70%
Coinsurance Max - Single	\$5,500	\$5,000
Coinsurance Max - Family	\$11,000	\$10,000
EE True Out of Pocket Max:	<u>In-Network</u> \$8,100 \$16,200	<u>Out-of-Network</u> N/A N/A
In-Network Employee Copay:	<u>Out-of-Network</u> N/A N/A	<u>Out-of-Network</u> N/A N/A
Office Visit	\$25	\$15
TeleMedicine Visit	\$25	\$15
Specialist Visit	\$50	\$40
Urgent Care	\$85	\$85
Emergency Room	\$250 after Deductible	\$250 after Deductible
Hospital Admission	20% after Deductible	30% after Deductible
Imaging	\$250 after Deductible	\$250 after Deductible
Employee In-Network RX Copay:		
Tier 1 / 1A: Generic	\$5	\$5
Tier 2: Preferred Brand	\$75	\$65
Tier 3: Non-Preferred Brand	\$95	\$85
Tier 4: Preferred Specialty	20% (\$250 Maximum)	20% (\$250 Maximum)
Tier 5: Non-Preferred Specialty	20% (\$450 Maximum)	20% (\$450 Maximum)
Prescription Formulary	N/A	N/A
Plan Provisions:		
Dependent Age	Not Included	Not Included
Pediatric Dental	Not Included	Not Included
Elective Abortion	Not Included	Not Included
Domestic Partner Rider	Included or Not Included	Included or Not Included
Monthly / Annual Premium	\$18,813.21	\$18,247.61
\$ Change from Current	\$225,758.52	\$218,971.32
% Change from Current	(-\$2,099.53) -10.04%	(\$2,665.13) -12.74%



Dental Policy # 4544
Renewal Date: 11/1/2022

Plan Provisions:

Network / UCR
Single Deductible
Two Person / Family Deductible
Calendar Year Max Per Person
Pediatric Dental EHB (Small Group Only)
Maximum Rollover
Preventative Advantage

Type I - Preventative Services:

Cleanings (Oral Prophylaxis)
Frequency on Routine Cleanings
Exams
X-Rays
Fluoride Treatments

Type II - Basic Services:

Fillings
Oral Surgery
Periodontics
Endodontics

Type III - Major Services:

Crowns / Onlays
Bridges / Dentures
Implants

Type IV - Child Orthodontics:

Orthodontics
Child Ortho Lifetime Max

Additional Details:

Participation Requirement
Dependent Age

Headcounts / Rates:

Single 20
EE & Spouse 3
EE & Child 2
EE & Children 1
Family 3
Total Enrolled 29

Rate Guarantee Duration:

Monthly / Annual Premium
\$ Change from Current
% Change from Current

	Current Delta Dental		Renewal Delta Dental		Reliance Standard			
	Delta PPO	Premier	Non-Participating	Delta PPO	Premier	Non-Participating	In-Network	Out-of-Network
	Delta Dental USA	Delta Dental USA	Non-Participating Fee	Delta Dental USA	Delta Dental USA	Non-Participating Fee	Ameritas	90th
	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50
	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150
	Included in Rates Not Included	Included in Rates Not Included	Included in Rates Not Included	Included in Rates Not Included	Included in Rates Not Included	Included in Rates Not Included	Included in Rates Not Included	\$1,500
	Included	Included	Included	Included	Included	Included	Not Included	Not Included
	100%	100%	100%	100%	100%	100%	100%	100%
	2x	2x	2x	2x	2x	2x	2x	2x
	100%	100%	100%	100%	100%	100%	100%	100%
	100%	100%	100%	100%	100%	100%	100%	100%
	80%	80%	80%	80%	80%	80%	80%	80%
	80%	80%	80%	80%	80%	80%	80%	80%
	80%	80%	80%	80%	80%	80%	80%	80%
	80%	80%	80%	80%	80%	80%	80%	80%
	50%	50%	50%	50%	50%	50%	50%	50%
	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	50%	50%
	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	Not Covered	Not Covered
	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	75% of all Eligible Employees To End of Year Age 26	75% of all Eligible Employees To End of Year Age 26	75% of all Eligible Employees To End of Year Age 26	75% of all Eligible Employees To End of Year Age 26	75% of all Eligible Employees To End of Year Age 26	75% of all Eligible Employees To End of Year Age 26	Greater of 60% or 10 Lives To End of Month Age 26	Greater of 60% or 10 Lives To End of Month Age 26
	\$49.96	\$49.96	\$49.96	\$49.96	\$49.96	\$49.96	\$42.43	\$42.43
	\$91.93	\$91.93	\$91.93	\$91.93	\$91.93	\$91.93	\$85.95	\$85.95
	\$91.93	\$91.93	\$91.93	\$91.93	\$91.93	\$91.93	\$103.56	\$103.56
	\$154.06	\$154.06	\$154.06	\$154.06	\$154.06	\$154.06	\$103.56	\$103.56
	\$154.06	\$154.06	\$154.06	\$154.06	\$154.06	\$154.06	\$147.08	\$147.08
	\$2,075.09	\$2,075.09	\$24,901.08	\$2,075.09	\$2,075.09	\$24,901.08	\$1,858.37	\$22,300.44
	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	(\$216.72)	(\$2,600.64)
	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-10.44%	-10.44%



Dental Policy # 4544
Renewal Date: 11/1/2022

Plan Provisions:

Network / UCR
Single Deductible
Two Person / Family Deductible
Calendar Year Max Per Person
Pediatric Dental EHB (Small Group Only)
Maximum Rollover
Preventative Advantage

Type I - Preventative Services:

Cleanings (Oral Prophylaxis)
Frequency on Routine Cleanings
Exams
X-Rays
Fluoride Treatments

Type II - Basic Services:

Fillings
Oral Surgery
Periodontics
Endodontics

Type III - Major Services:

Crowns / Onlays
Bridges / Dentures
Implants

Type IV - Child Orthodontics:

Orthodontics
Child Ortho Lifetime Max

Additional Details:

Participation Requirement
Dependent Age

Headcounts / Rates:

Single 20
EE & Spouse 3
EE & Child 2
EE & Children 1
Family 3
Total Enrolled 29

Rate Guarantee Duration:

Monthly / Annual Premium
\$ Change from Current
% Change from Current

	Current Delta Dental			Renewal Delta Dental			UNUM
	Delta PPO	Premier	Non-Participating	Delta PPO	Premier	Non-Participating	
			Fee			Fee	
	Delta Dental USA	Delta Dental USA	Non-Participating Fee	Delta Dental USA	Delta Dental USA	Non-Participating Fee	
	\$50	\$50	\$50	\$50	\$50	\$50	DentalMax 90th
	\$150	\$150	\$150	\$150	\$150	\$150	\$50 \$50
	\$1,500	\$1,500		\$1,500	\$1,500		\$150 \$150
	Included in Rates	Included in Rates		Included in Rates	Included in Rates		\$1,500
	Not Included	Not Included		Not Included	Not Included		Included in Rates
	Included	Included		Included	Included		Included
	100%	100%	100%	100%	100%	100%	Not Included
	2x	2x	2x	2x	2x	2x	Not Included
	100%	100%	100%	100%	100%	100%	100%
	100%	100%	100%	100%	100%	100%	100%
	100%	100%	100%	100%	100%	100%	100%
	80%	80%	80%	80%	80%	80%	90%
	80%	80%	80%	80%	80%	80%	90%
	80%	80%	80%	80%	80%	80%	90%
	80%	80%	80%	80%	80%	80%	90%
	50%	50%	50%	50%	50%	50%	60%
	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	60%
	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	60%
	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	75% of all Eligible Employees	75% of all Eligible Employees		75% of all Eligible Employees	75% of all Eligible Employees		Minimum 10 Enrolled
	To End of Year Age 26	To End of Year Age 26		To End of Year Age 26	To End of Year Age 26		To End of Year Age 26
	\$49.96	\$49.96		\$49.96	\$49.96		\$47.84
	\$91.93	\$91.93		\$91.93	\$91.93		\$94.36
	\$91.93	\$91.93		\$91.93	\$91.93		\$105.94
	\$154.06	\$154.06		\$154.06	\$154.06		\$105.94
	\$154.06	\$154.06		\$154.06	\$154.06		\$163.26
	\$2,075.09	\$2,075.09	\$24,901.08	\$2,075.09	\$2,075.09	\$24,901.08	\$2,047.48
	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	(\$27.61)
	0.00%	0.00%		0.00%	0.00%		(\$331.32)
							-1.33%
	12 Months	12 Months		12 Months	12 Months		12 Months



Dental Policy # 4544
Renewal Date: 11/1/2022

Plan Provisions:

Network / UCR
Single Deductible
Two Person / Family Deductible
Calendar Year Max Per Person
Pediatric Dental EHB (Small Group Only)
Maximum Rollover
Preventative Advantage

Type I - Preventative Services:

Cleanings (Oral Prophylaxis)
Frequency on Routine Cleanings
Exams
X-Rays
Fluoride Treatments

Type II - Basic Services:

Fillings
Oral Surgery
Periodontics
Endodontics

Type III - Major Services:

Crowns / Onlays
Bridges / Dentures
Implants

Type IV - Child Orthodontics:

Orthodontics
Child Ortho Lifetime Max

Additional Details:

Participation Requirement
Dependent Age

Headcounts / Rates:

Single 20
EE & Spouse 3
EE & Child 2
EE & Children 1
Family 3
Total Enrolled 29

Rate Guarantee Duration:

Monthly / Annual Premium
\$ Change from Current
% Change from Current

	Current Delta Dental		Renewal Delta Dental		Guardian			
	Delta PPO	Premier	Non-Participating	Delta PPO	Premier	Non-Participating	In-Network	Out-of-Network
	Delta Dental USA	Delta Dental USA	Non-Participating Fee	Delta Dental USA	Delta Dental USA	Non-Participating Fee	DentalGuard Preferred	90th
	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50
	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150
	\$1,500	\$1,500		\$1,500	\$1,500		\$1,500	\$1,500
	Included in Rates	Included in Rates	Included in Rates	Included in Rates	Included in Rates	Included in Rates	Included in Rates	Included in Rates
	Not Included	Not Included	Not Included	Not Included	Not Included	Not Included	Included	Included
	Included	Included	Included	Included	Included	Included	Included	Included
	100%	100%	100%	100%	100%	100%	100%	100%
	2x	2x	2x	2x	2x	2x	2x	2x
	100%	100%	100%	100%	100%	100%	100%	100%
	100%	100%	100%	100%	100%	100%	100%	100%
	80%	80%	80%	80%	80%	80%	80%	80%
	80%	80%	80%	80%	80%	80%	80%	80%
	80%	80%	80%	80%	80%	80%	80%	80%
	80%	80%	80%	80%	80%	80%	80%	80%
	50%	50%	50%	50%	50%	50%	50%	50%
	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	50%	50%
	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	50%	50%
	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	75% of all Eligible Employees	75% of all Eligible Employees	75% of all Eligible Employees	75% of all Eligible Employees	75% of all Eligible Employees	75% of all Eligible Employees	85% of Eligible Employees	85% of Eligible Employees
	To End of Year Age 26	To End of Year Age 26	To End of Year Age 26	To End of Year Age 26	To End of Year Age 26	To End of Year Age 26	To End of Year Age 26	To End of Year Age 26
	\$49.96	\$49.96	\$49.96	\$49.96	\$49.96	\$49.96	\$49.96	\$49.96
	\$91.93	\$91.93	\$91.93	\$91.93	\$91.93	\$91.93	\$91.96	\$91.96
	\$91.93	\$91.93	\$91.93	\$91.93	\$91.93	\$91.93	\$91.93	\$91.93
	\$154.06	\$154.06	\$154.06	\$154.06	\$154.06	\$154.06	\$154.06	\$154.06
	\$154.06	\$154.06	\$154.06	\$154.06	\$154.06	\$154.06	\$154.06	\$154.06
	\$2,075.09	\$2,075.09	\$24,901.08	\$2,075.09	\$2,075.09	\$24,901.08	\$2,075.18	\$24,902.16
	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.09	\$1.08
	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	12 Months	12 Months	12 Months	12 Months	12 Months	12 Months	12 Months	12 Months



Dental Policy # 4544
 Renewal Date: 11/1/2022

Plan Provisions:

Network / UCR
 Single Deductible
 Two Person / Family Deductible
 Calendar Year Max Per Person
 Pediatric Dental EHB (Small Group Only)
 Maximum Rollover
 Preventative Advantage

Type I - Preventative Services:

Cleanings (Oral Prophylaxis)
 Frequency on Routine Cleanings
 Exams
 X-Rays
 Fluoride Treatments

Type II - Basic Services:

Fillings
 Oral Surgery
 Periodontics
 Endodontics

Type III - Major Services:

Crowns / Onlays
 Bridges / Dentures
 Implants

Type IV - Child Orthodontics:

Orthodontics
 Child Ortho Lifetime Max

Additional Details:

Participation Requirement
 Dependent Age

Headcounts / Rates:

Single	20
EE & Spouse	3
EE & Child	2
EE & Children	1
Family	3
Total Enrolled	29

Rate Guarantee Duration:

Monthly / Annual Premium	\$2,075.09	\$24,901.08	\$2,075.09	\$24,901.08
% Change from Current		\$0.00		\$0.00
% Change from Current		0.00%		0.00%

	Current Delta Dental		Renewal Delta Dental		UNUM		
	Delta PPO	Premier	Non-Participating	Premier	Non-Participating	In-Network	Out-of-Network
Delta PPO	Delta Dental USA	Delta Dental USA	Delta Dental USA	Delta Dental USA	Delta Dental USA	DenteMax	90th
Single Deductible	\$50	\$50	\$50	\$50	\$50	\$50	\$50
Two Person / Family Deductible	\$150	\$150	\$150	\$150	\$150	\$150	\$150
Calendar Year Max Per Person	\$1,500	\$1,500	\$1,500	\$1,500	\$1,500	Included in Rates	Included in Rates
Pediatric Dental EHB (Small Group Only)	Included in Rates	Included in Rates	Included in Rates	Included in Rates	Included in Rates	Included in Rates	Included in Rates
Maximum Rollover	Not Included	Not Included	Not Included	Not Included	Not Included	Not Included	Not Included
Preventative Advantage	Included	Included	Included	Included	Included	Included	Included
Type I - Preventative Services:							
Cleanings (Oral Prophylaxis)	100%	100%	100%	100%	100%	100%	100%
Frequency on Routine Cleanings	2x	2x	2x	2x	2x	2x	2x
Exams	100%	100%	100%	100%	100%	100%	100%
X-Rays	100%	100%	100%	100%	100%	100%	100%
Fluoride Treatments	100%	100%	100%	100%	100%	100%	100%
Type II - Basic Services:							
Fillings	80%	80%	80%	80%	80%	90%	90%
Oral Surgery	80%	80%	80%	80%	80%	90%	90%
Periodontics	80%	80%	80%	80%	80%	90%	90%
Endodontics	80%	80%	80%	80%	80%	90%	90%
Type III - Major Services:							
Crowns / Onlays	50%	50%	50%	50%	50%	60%	60%
Bridges / Dentures	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	60%	60%
Implants	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	50%	50%
Child Ortho Lifetime Max						\$1,000	
Additional Details:							
Participation Requirement	75% of all Eligible Employees	75% of all Eligible Employees	75% of all Eligible Employees	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	To End of Year Age 26	To End of Year Age 26	To End of Year Age 26	
Headcounts / Rates:							
Single	\$49.96	\$49.96	\$49.96	\$49.96	\$49.96	\$47.84	
EE & Spouse	\$91.93	\$91.93	\$91.93	\$91.93	\$91.93	\$94.36	
EE & Child	\$91.93	\$91.93	\$91.93	\$91.93	\$91.93	\$111.58	
EE & Children	\$154.06	\$154.06	\$154.06	\$154.06	\$154.06	\$111.58	
Family	\$154.06	\$154.06	\$154.06	\$154.06	\$154.06	\$169.94	
Total Enrolled							
Rate Guarantee Duration:							
Monthly / Annual Premium	\$2,075.09	\$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%			0.00%	0.45%	



Dental Policy # 4544
Renewal Date: 11/1/2022

Plan Provisions:

Network / UCR
Single Deductible
Two Person / Family Deductible
Calendar Year Max Per Person
Pediatric Dental EHB (Small Group Only)
Maximum Rollover
Preventative Advantage

Type I - Preventative Services:

Cleanings (Oral Prophylaxis)
Frequency on Routine Cleanings
Exams
X-Rays
Fluoride Treatments

Type II - Basic Services:

Fillings
Oral Surgery
Periodontics
Endodontics

Type III - Major Services:

Crowns / Onlays
Bridges / Dentures
Implants

Type IV - Child Orthodontics:

Orthodontics
Child Ortho Lifetime Max

Additional Details:

Participation Requirement
Dependent Age

Headcounts / Rates:

Single 20
EE & Spouse 3
EE & Child 2
EE & Children 1
Family 3
Total Enrolled 29

Rate Guarantee Duration:

Monthly / Annual Premium
\$ Change from Current
% Change from Current

	Current Delta Dental		Renewal Delta Dental		Delta Dental				
	Delta PPO	Non-Participating	Delta PPO	Premier	Non-Participating	Premier	Delta PPO	Premier	Nonparticipating
	Delta Dental USA	Non-Participating Fee	Delta Dental USA	Delta Dental USA	Non-Participating Fee	Delta Dental USA	Delta Dental USA	Delta Dental USA	Non-Participating Fee
	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50
	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150
	\$1,500	\$1,500	\$1,500	\$1,500	\$1,500	\$2,000	\$2,000	\$2,000	\$2,000
	Included in Rates	Included in Rates	Included in Rates	Included in Rates	Included in Rates	Included in Rates	Included in Rates	Included in Rates	Included in Rates
	Not Included	Not Included	Not Included	Not Included	Not Included	Not Included	Not Included	Not Included	Not Included
	Included	Included	Included	Included	Included	Included	Included	Included	Included
	100%	100%	100%	100%	100%	100%	100%	100%	100%
	2x	2x	2x	2x	2x	2x	2x	2x	2x
	100%	100%	100%	100%	100%	100%	100%	100%	100%
	100%	100%	100%	100%	100%	100%	100%	100%	100%
	80%	80%	80%	80%	80%	80%	80%	80%	80%
	80%	80%	80%	80%	80%	80%	80%	80%	80%
	80%	80%	80%	80%	80%	80%	80%	80%	80%
	80%	80%	80%	80%	80%	80%	80%	80%	80%
	50%	50%	50%	50%	50%	50%	50%	50%	50%
	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%
	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%	80% / 50%
	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	75% of all Eligible Employees	75% of all Eligible Employees	75% of all Eligible Employees	75% of all Eligible Employees	75% of all Eligible Employees	75% of all Eligible Employees	75% of all Eligible Employees	75% of all Eligible Employees	75% of all Eligible Employees
	To End of Year Age 26	To End of Year Age 26	To End of Year Age 26	To End of Year Age 26	To End of Year Age 26	To End of Year Age 26	To End of Year Age 26	To End of Year Age 26	To End of Year Age 26
	\$49.96	\$49.96	\$49.96	\$49.96	\$49.96	\$51.21	\$51.21	\$51.21	\$51.21
	\$91.93	\$91.93	\$91.93	\$91.93	\$91.93	\$94.17	\$94.17	\$94.17	\$94.17
	\$91.93	\$91.93	\$91.93	\$91.93	\$91.93	\$94.17	\$94.17	\$94.17	\$94.17
	\$154.06	\$154.06	\$154.06	\$154.06	\$154.06	\$157.33	\$157.33	\$157.33	\$157.33
	\$154.06	\$154.06	\$154.06	\$154.06	\$154.06	\$157.33	\$157.33	\$157.33	\$157.33
	12 Months	12 Months	12 Months	12 Months	12 Months				
	\$2,075.09	\$2,075.09	\$2,075.09	\$2,075.09	\$2,075.09	\$2,124.37	\$2,124.37	\$2,124.37	\$2,124.37
	\$24,901.08	\$24,901.08	\$24,901.08	\$24,901.08	\$24,901.08	\$49.28	\$49.28	\$49.28	\$49.28
	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$591.36	\$591.36	\$591.36	\$591.36
	0.00%	0.00%	0.00%	0.00%	0.00%	2.37%	2.37%	2.37%	2.37%

