



## Ancillary Monthly Rate Sheet

Rates for Effective Dates - 10/1/2017 - 11/1/2017 - 12/1/2017

Dental			
<b>Guardian Managed DentalGuard (DMO) - No minimum participation</b>		<b>Two Tier</b>	<b>Four Tier</b>
<ul style="list-style-type: none"> <li>\$5 copay for each primary care office visit (includes a cleaning, one set of x-rays, checkup and second visit includes cleaning only)</li> <li>No annual maximum on the plan and offers fixed patient charges for basic and major services</li> <li>Most diagnostic and preventive services are provided at no additional cost</li> <li>No deductible</li> </ul>	Employee	\$16.35	\$16.35
	Emp/Spouse	n/a	\$32.82
	Emp/Child(ren)	n/a	\$33.97
	Family	\$43.27	\$50.32
<b>Guardian DentalGuard Preferred (Dual Option DMO/PPO) - 75% participation, excluding dental waivers</b>			
<ul style="list-style-type: none"> <li>No referrals needed to see a specialist</li> <li>Out-of-area emergency coverage</li> <li>\$50 deductible for In-Network services/\$75 deductible for Out-of-Network services</li> <li>Annual maximum of \$1,000 In-Network-rollover</li> <li>Implant benefit</li> </ul>	Employee	\$45.86	\$45.86
	Emp/Spouse	n/a	\$96.37
	Emp/Child(ren)	n/a	\$87.86
	Family	\$123.58	\$140.40
<b>Guardian Managed DentalGuard Plus (DMO Plus) - No minimum participation</b>			
<ul style="list-style-type: none"> <li>\$5 copay for each primary care office visit (includes a cleaning, one set of x-rays, checkup and second visit includes cleaning only)</li> <li>No annual maximum, the Plus plan offers a lower fixed patient charges for basic and major services than the standard DMO plan</li> <li>Most diagnostic and preventive services are provided at no additional cost</li> <li>No deductible</li> </ul>	Employee	\$19.31	\$19.31
	Emp/Spouse	n/a	\$38.61
	Emp/Child(ren)	n/a	\$42.43
	Family	\$51.11	\$61.74
<b>Guardian DentalGuard Preferred Plus (Dual Option DMO Plus/PPO Plus) - 75% participation, excluding dental waivers</b>			
<ul style="list-style-type: none"> <li>No referrals are needed to see a specialist</li> <li>Includes out-of-area emergency coverage</li> <li>\$50 deductible for In-Network services/\$50 deductible for Out-of-Network services</li> <li>Annual maximum of \$1,500 In-Network-rollover</li> <li>Implant benefit</li> </ul>	Employee	\$52.45	\$52.45
	Emp/Spouse	n/a	\$110.44
	Emp/Child(ren)	n/a	\$100.71
	Family	\$141.05	\$160.90
<b>Solstice Dental EPO - No minimum participation</b>		<b>Four Tier</b>	
<ul style="list-style-type: none"> <li>\$0 copay for primary care office visit (includes a cleaning, one set of x-rays, checkup and second visit includes cleaning only)</li> <li>Open access and no specialist referrals</li> <li>Most diagnostic and preventive services are provided at no additional cost</li> <li>No deductible, no calendar maximum</li> <li>Implant benefit</li> </ul>	Employee	\$18.83	
	Emp/Spouse	\$32.95	
	Emp/Child(ren)	\$40.80	
	Family	\$51.78	
<b>Solstice Dental PPO - No minimum participation</b>		<b>Four Tier</b>	
<ul style="list-style-type: none"> <li>No referrals needed to see a specialist</li> <li>\$50 deductible for In-Network services/\$50 deductible for Out-of-Network services</li> <li>Annual maximum of \$2,000 In-Network-rollover</li> <li>Implant benefit</li> </ul>	Employee	\$58.90	
	Emp/Spouse	\$105.14	
	Emp/Child(ren)	\$124.07	
	Family	\$163.04	

Rates are subject to final verification at the time of enrollment. Domestic Partner coverage is included with all carriers. Rates for Domestic Partners will be the same as rates for Employee/Spouse and Family. This is a summary of plan information. Please refer to the Eligibility Guidelines for further information. The following billing and administrative fees apply to the following products:

- Guardian DentalGuard Preferred & Plus plans: EE \$9.25, EE/Spouse \$18.25, EE+Child(ren) \$16.50, Family \$26.50
- Guardian VisionGuard: \$1.50
- Guardian EverGuard & EverGuard Plus plans: \$3.50
- Solstice PPO: EE \$9.25, EE/Spouse \$18.25, EE+Child(ren) \$16.50, Family \$26.50
- Solstice Vision: \$1.50

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<b>Vision</b>			
<b>Guardian VisionGuard - 20% participation, excluding vision waivers</b>		<b>Two Tier</b>	<b>Four Tier</b>
<ul style="list-style-type: none"> <li>● \$10 copay for an exam every 12 months</li> <li>● \$25 copay for materials every 24 months</li> <li>● Davis Vision In-Network; Out-of-Network access as well</li> </ul>	<b>Employee</b>	<b>\$6.93</b>	<b>\$6.93</b>
	<b>Emp/Spouse</b>	n/a	<b>\$10.62</b>
	<b>Emp/Child(ren)</b>	n/a	<b>\$10.80</b>
	<b>Family</b>	<b>\$13.17</b>	<b>\$16.23</b>
<b>Solstice Vision - No minimum participation</b>		<b>Four Tier</b>	
<ul style="list-style-type: none"> <li>● \$10 copay for an exam every 12 months</li> <li>● \$25 copay for lenses &amp; contact lenses every 12 months</li> <li>● \$25 copay for frames every 24 months</li> <li>● Davis Vision In-Network; Out-of-Network access as well</li> </ul>	<b>Employee</b>	<b>\$7.72</b>	
	<b>Emp/Spouse</b>	<b>\$12.39</b>	
	<b>Emp/Child(ren)</b>	<b>\$15.00</b>	
	<b>Family</b>	<b>\$18.61</b>	

<b>Bundled Life &amp; Disability</b>		
<b>EverGuard - No minimum participation</b>	<b>Employee Ages</b>	<b>Three Tier</b>
<ul style="list-style-type: none"> <li>● \$1,000 per month of disability income</li> <li>● \$25,000 of Term Life Insurance</li> <li>● \$75,000 of Accidental Death &amp; Dismemberment Insurance</li> <li>● Guaranteed Issued</li> </ul>	<b>18-39</b>	<b>\$13.50</b>
	<b>40-54</b>	<b>\$26.00</b>
	<b>55+</b>	<b>\$48.50</b>
<b>EverGuard Plus - No minimum participation</b>	<b>Employee Ages</b>	<b>Three Tier</b>
<ul style="list-style-type: none"> <li>● \$1,500 per month of disability income</li> <li>● \$50,000 of Term Life Insurance</li> <li>● \$100,000 of Accidental Death &amp; Dismemberment Insurance</li> <li>● Guaranteed Issued</li> </ul>	<b>18-39</b>	<b>\$21.50</b>
	<b>40-54</b>	<b>\$39.50</b>
	<b>55+</b>	<b>\$75.50</b>

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- Solstice Vision: \$1.50