



NEW Ancillary Benefit Options
Available 10/1/2022



Top Dental Plans

* There are other plan options that include Voluntary plans

Plan Description	Plan A - ER Paid - no ortho	Plan C - ER Paid - no ortho
	In-Network	In-Network
Reimbursement	Negotiated Fee Schedule	Negotiated Fee Schedule
Type A - Preventive	100%	100%
Type B - Basic	80%	80%
Type C - Major	50%	50%
Calendar Year	B & C	B & C
Deductible applies to:	\$50	\$50
* Individual	\$150	\$150
* Family	Aggregate	Aggregate
Calendar Year Maximum (applies to A, B, C services)	\$1,000	\$1,500
Rates	*Rates are guaranteed through 9/1/23	
Employee Only	\$17.37	19.59
Employee + Spouse	\$34.69	39.09
Employee + Child(ren)	\$37.00	40.29
Family	\$57.93	63.63

Check here to elect plan

Top Vision Plans

* There are other plan options that include Voluntary plans

Plan Description	Plan A - M130A-5/10	Plan C - M130D-10/20	Plan D - M130D-20/20
	In-Network	In-Network	In-Network
Reimbursement	In-Network	In-Network	In-Network
Eye Examination			
* Comprehensive exam	\$5 copay	\$10 copay	\$20 copay
* Reinal Imaging	Up to \$39 copay	Up to \$39 copay	Up to \$39 copay
Materials / Eyewear			
* Single Vision	\$10 copay	\$20 copay	\$20 copay
* Lined bifocal	\$10 copay	\$20 copay	\$20 copay
* Lined trifocal	\$10 copay	\$20 copay	\$20 copay
* Lenticular	\$10 copay	\$20 copay	\$20 copay
Frame Allowance			
* Costco, Walmart and Sam's Club	\$130 allowance * \$70 allowance	\$130 allowance * \$70 allowance	\$130 allowance * \$70 allowance
Contacts			
* Elective	\$130 Allowance	\$130 Allowance	\$130 Allowance
* Contact Fitting & Eval.	Up to \$60 copay	Up to \$60 copay	Up to \$60 copay
Rates	*Rates are guaranteed through 9/1/23		
Employee Only	\$10.56	\$7.73	\$6.78
Employee + Spouse	\$21.15	\$15.50	\$13.60
Employee + Child(ren)	\$17.91	\$13.13	\$11.51
Family	\$29.53	\$21.65	\$18.97

Check here to elect plan

Group Life

Basic Life \$25,000 (per \$1,000 of Covered Volume)	\$0.183	Basic Life \$50,000 (per \$1,000 of Covered Volume)	\$0.183
Basic AD&D \$25,000 (per \$1,000 of Covered Volume)	\$0.028	Basic AD&D \$50,000 (per \$1,000 of Covered Volume)	\$0.028
Total Monthly Premium (per employee)	\$5.28	Total Monthly Premium (per employee)	\$10.55

*Rates are guaranteed through 9/1/25

STD Disability

Injury - 14 days, Sickness - 14 days, Duration - 13 weeks
Maximum Monthly Benefit - \$750

Benefit amount is 60% of your predisability weekly earnings, subjected to the max benefit allowance

Short Term Disability (per \$10 Covered Weekly Benefit)	Rates	Monthly Premium per employee based on \$30,000 salary
<25	\$0.680	\$23.54
25-29	\$0.720	\$24.92
30-34	\$0.740	\$25.62
35-39	\$0.670	\$23.19
40-44	\$0.720	\$24.92
45-49	\$0.880	\$30.46
50-54	\$1.090	\$37.73
55-59	\$1.330	\$46.04
60-64	\$1.580	\$54.69
65+	\$1.890	\$65.42

*Rates are guaranteed through 9/1/24

LTD Disability

Elimination Period 90 days, Maximum benefit period 24 months
Maximum Monthly Benefit - \$4,000

Benefit amount is 60% of your predisability monthly earnings, subjected to the max benefit allowance

Short Term Disability (per \$100 Covered Weekly Benefit)	Rates	Monthly Premium per employee based on \$30,000 salary
<35	0.191	\$2.87
35-39	0.36	\$5.40
40-44	0.488	\$7.32
45-49	0.693	\$10.40
50-54	1.038	\$15.57
55-59	1.542	\$23.13
60-64	1.614	\$24.21
65+	0.606	\$9.09

*Rates are guaranteed through 9/1/24

Plans Elected

1 _____
2 _____
3 _____
4 _____

Group Authorized Signature
