SIHO Dental Premium Rates: Rates effective through 06/30/2017

Base Plans

Benefits	Preferred Plan	Standard Plan	Value Plan
Individual Deductible (Family @ 3 Times)	$50	$75	$100
Calendar Year Maximum	$1,250	$1,000	$750
Preventive Coverage	100%	100%	100%
Diagnostic Coverage	100%	80%	60%
Basic Services Coverage	80%	60%	50%
Major Services Coverage	60%	50%	40%
Orthodontia Coverage	60%	50%	Not Covered
Orth Calendar Year Max	$625	$500	Not Covered
Ortho Lifetime Maximum	$1,250	$1,000	Not Covered

(Major and Orthodontia Services have a 12 month waiting period if no prior group coverage was in force)

4 Tier Monthly Rates for Employers

	Preferred Plan	Standard Plan	Value Plan
	Groups with no previous coverage		
Employee Only	$40.14	$26.24	$21.48
Employee + Spouse	$80.28	$52.49	$42.96
Employee + Child(ren)	$107.09	$68.06	$48.02
Family	$147.23	$94.30	$69.50

	Groups with comparable previous coverage		
Employee Only	$45.66	$29.76	$24.09
Employee + Spouse	$91.37	$59.51	$48.17
Employee + Child(ren)	$125.99	$79.44	$53.86
Family	$171.67	$109.20	$77.94

*Rates are applicable to employee and each dependent.

SIHO Dental Premium Rates: Rates effective through 06/30/2017

Increase Maximums by $500 (Preferred and Standard Plans Only)

Benefits	Preferred Plan	Standard Plan	Value Plan
Individual Deductible *(Family @ 3 Times)*	$50	$75	$100
Calendar Year Maximum	**$1,750**	**$1,500**	$750
Preventive Coverage	100%	100%	100%
Diagnostic Coverage	100%	80%	60%
Basic Services Coverage	80%	60%	50%
Major Services Coverage	60%	50%	40%
Orthodontia Coverage	60%	50%	Not Covered
Orthodontia Calendar Year Maximum	$625	$500	Not Covered
Ortho Lifetime Maximum	$1,250	$1,000	Not Covered

(Major and Orthodontia Services have a 12 month waiting period if no prior group coverage was in force)

4 Tier Monthly Rates for Employers

	Preferred Plan	Standard Plan	Value Plan
	Groups with no previous coverage		
Employee Only	$42.43	$28.61	$21.48
Employee + Spouse	$84.85	$57.21	$42.96
Employee + Child(ren)	$113.20	$74.19	$48.02
Family	$155.63	$102.79	$69.50
	Groups with comparable previous coverage		
Employee Only	$48.29	$32.43	$24.09
Employee + Spouse	$96.58	$64.87	$48.17
Employee + Child(ren)	$133.17	$86.59	$53.86
Family	$181.46	$119.02	$77.94

*Rates are applicable to employee and each dependent.

SIHO Dental Premium Rates: Rates effective through 06/30/2017

Increase Maximums by $1,000 (Preferred and Standard Plans Only)

Benefits	Preferred Plan	Standard Plan	Value Plan
Individual Deductible *(Family @ 3 Times)*	$50	$75	$100
Calendar Year Maximum	**$2,250**	**$2,000**	$750
Preventive Coverage	100%	100%	100%
Diagnostic Coverage	100%	80%	60%
Basic Services Coverage	80%	60%	50%
Major Services Coverage	60%	50%	40%
Orthodontia Coverage	60%	50%	Not Covered
Orthodontia Calendar Year Maximum	$625	$500	Not Covered
Ortho Lifetime Maximum	$1,250	$1,000	Not Covered

(Major and Orthodontia Services have a 12 month waiting period if no prior group coverage was in force)

4 Tier Monthly Rates for Employers

	Preferred Plan	Standard Plan	Value Plan
	Groups with no previous coverage		
Employee Only	$43.75	$29.81	$21.48
Employee + Spouse	$87.50	$59.63	$42.96
Employee + Child(ren)	$116.73	$77.32	$48.02
Family	$160.48	$107.13	$69.50

	Groups with comparable previous coverage		
Employee Only	$49.80	$33.80	$24.09
Employee + Spouse	$99.59	$67.60	$48.17
Employee + Child(ren)	$137.33	$90.25	$53.86
Family	$187.12	$124.05	$77.94

*Rates are applicable to employee and each dependent.