DENTON ISD						
DENTAL COMPARISON					PROPOSED	PROPOSED
9/1/2017						
Carrier	The Standard / Current	The Standard / Current	The Standard / Renewal	The Standard / Renewal	Cigna	Cigna
	Low Plan	High Plan	Low Plan	High Plan	Proposed Low Plan	Proposed High Plan
Deductible / Family Max	$50 x All	$50 x All	$50 x All	$50 x All	$50 x All	$50 x All
Annual Maximum	$950	$1,700	$950	$1,700	$950	$1,700
Diagnostic & Preventive						
Reimbursement Percentage	90%	100%	90%	100%	90%	100%
Waiting Period	N/A	N/A	N/A	N/A	N/A	N/A
Basic Services						
Reimbursement Percentage	70%	80%	70%	80%	70%	80%
Waiting Period	12 Months / Late Entrant	N/A	12 Months / Late Entrant	N/A	N/A	N/A
Copay	$10	$10	$10	$10	$0	$0
Major Services						
Reimbursement Percentage	40%	50%	40%	50%	40%	50%
Waiting Period	12 Months / Late Entrant	N/A	12 Months / Late Entrant	N/A	N/A	N/A
Ortho Services						
Reimbursement Percentage	N/A	50%	N/A	50%	N/A	50%
Waiting Period	N/A	No Waiting Period	N/A	No Waiting Period	N/A	No Waiting Period
Eligibility	N/A	Under19	N/A	Under19	N/A	Under19
Lifetime Max.	N/A	$1,500	N/A	$1,500	N/A	$1,500
Network Reimbursement R&C						
In-network	Actual Charges	Actual Charges	Actual Charges	Actual Charges	Actual Charges	Actual Charges
Out-of-Network	MAC	90%	MAC	90%	MAC	90%
MISC						
Endo/Perio:	40%	80%	40%	80%	40%	80%
Dependent Eligibility:	26	26	26	26	26	26
Rollover Benefit	Yes	Yes	Yes	Yes	Yes / $100 per year	Yes / $100 per year
Implant	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Unique Locations General	Undisclosed	Undisclosed	Undisclosed	Undisclosed	DHMO- 311 and DPPO-15,158	DHMO- 311 and DPPO-15,158
Provider Network	Ameritas	Ameritas	Ameritas	Ameritas	Cigna DPPO	Cigna DPPO
Rate Guarantee	12 Months	12 Months	12 Months	12 Months	24 Months	24 Months
4-Tier Monthly Rates						
Employee Only	$16.68	$39.56	$20.85	$49.45	$18.69	$44.32
Employee + Spouse	$33.17	$84.52	$41.46	$105.65	$37.16	$94.70
Employee + Children	$35.93	$76.62	$44.91	$95.77	$40.26	$85.84
Employee + Family	$52.44	$142.77	$65.55	$178.45	$58.75	$159.96
% Difference From Current			20.00%	20.00%	10.75%	10.74%
Notes: Lowering the Annual to 750/1500 will have a positive impact on rates of approximately 3%	Copay for basic Services	Copay for basic Services	Copay for basic Services	Copay for basic Services	Allow 2 Cleanings per year, as opposed to 1 every 6 months / No Waiting periods. Very good network. No Copay for Basic	Allow 2 Cleanings per year, as opposed to 1 every 6 months / No Waiting periods. Very good network. No Copay for Basic

DENTON ISD					
DENTAL COMPARISON	PROPOSED				
9/1/2017					
Carrier	Cigna	Beam Dental	Beam Dental	United Concordia	United Concordia
	Proposed DHMO	Proposed Low Plan	Proposed High Plan	Proposed Low Plan	Proposed High Plan
Deductible / Family Max	Co-Pay	$50 x All	$50 x All	$50 / $150	$50 / $150
Annual Maximum	No Annual Max	$1,000	$1,700	$950	$1,700
Diagnostic & Preventive					
Reimbursement Percentage	Co-Pay	90%	100%	90%	100%
Waiting Period	N/A	N/A	N/A	N/A	N/A
Basic Services					
Reimbursement Percentage	Co-Pay	70%	80%	70%	80%
Waiting Period	N/A	No	No	No	No
Copay	Varies	$0	$0	$0	$0
Major Services					
Reimbursement Percentage	Co-Pay	40%	50%	40%	50%
Waiting Period	N/A	No	No	No	No
Ortho Services					
Reimbursement Percentage	Co-Pay	N/A	50%	N/A	50%
Waiting Period	No Waiting Period	N/A	No Waiting Period	N/A	No Waiting Period
Eligibility	Under19	N/A	Under19	N/A	Under19
Lifetime Max.	No Max	N/A	$1,500	N/A	$1,500
Network Reimbursement R&C					
In-network	Actual Charges	Actual Charges	Actual Charges	Actual Charges	Actual Charges
Out-of-Network	N/A	MAC	90%	MAC	90%
MISC					
Endo/Perio:	Co_Pay	40%	80%	40%	50%
Dependent Eligibility:	26	26	26	26	26
Rollover Benefit	N/A	Yes	Yes	No	No
Implant	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Unique Locations General	DHMO- 311 and DPPO-15,158	742	742	20964	20964
Provider Network	Cigna DHMO	Stratose	Stratose	PDP	PDP
Rate Guarantee	24 Months	24 Months	24 Months	24 Months	24 Months
4-Tier Monthly Rates					
Employee Only	$13.31	$16.08	$38.14	$17.30	$50.08
Employee + Spouse	$26.50	$31.98	$81.48	$41.99	$107.00
Employee + Children	$28.63	$34.64	$73.86	$45.48	$97.00
Employee + Family	$41.81	$50.55	$137.63	$66.39	$180.00
% Difference From Current	N/A	-3.73%	-3.72%	3.58%	21.01%
Notes: Lowering the Annual to 750/1500 will have a positive impact on rates of approximately 3%	True DHMO with no out of network benefit, and co-pays	Relatively new provider. Numerous perks which include Sonic Powered Smart Toothbrush, Replacement Heads, Beam toothpaste, Beam Floss, Free Shipping on Floss, Paste and Heads every 3 months.	Relatively new provider. Numerous perks which include Sonic Powered Smart Toothbrush, Replacement Heads, Beam toothpaste, Beam Floss, Free Shipping on Floss, Paste and Heads every 3 months.	1 year rate guaramtee with 6% cap on year 2. Proposed higher limits	1 year rate guaramtee with 6% cap on year 2. Proposed higher limits

DENTON ISD							
DENTAL COMPARISON							
9/1/2017							
Carrier	BCBS	BCBS	Delta Dental	Delta Dental	UHC	Liberty Dental	Liberty Dental
	Proposed Low Plan	Proposed High Plan	Proposed Low Plan	Proposed High Plan	Proposed High Plan	Proposed Low Plan	Proposed High Plan
Deductible / Family Max	$50 x All	$50 x All	$50 x All	$50 x All	$50 x All	$50 / $150	$50 / $150
Annual Maximum	$1,000	$1,700	$950	$1,700	$1,700	$1,000	$1,700
Diagnostic & Preventive							
Reimbursement Percentage	90%	100%	90%	100%	100%	90%	100%
Waiting Period	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Basic Services							
Reimbursement Percentage	70%	80%	70%	80%	80%	70%	80%
Waiting Period	No	No	No	No	12 Months	No	No
Copay	$0	$0	$0	$0	$0	$0	$0
Major Services							
Reimbursement Percentage	40%	50%	40%	50%	50%	40%	50%
Waiting Period	No	No	No	No	12 Months	No	No
Ortho Services							
Reimbursement Percentage	N/A	50%	N/A	50%	50%	N/A	50%
Waiting Period	N/A	No Waiting Period	N/A	No Waiting Period	No Waiting Period	N/A	No Waiting Period
Eligibility	N/A	Under19	N/A	Under19	Under19	N/A	Under19
Lifetime Max.	N/A	$1,500	N/A	$1,500	$1,500	N/A	$1,500
Network Reimbursement R&C							
In-network	Actual Charges	Actual Charges	Actual Charges	Actual Charges	Actual Charges	Actual Charges	Actual Charges
Out-of-Network	MAC	90%	MAC	90%	90%	MAC	90%
MISC							
Endo/Perio:	40%	80%	40%	80%	80%	40%	80%
Dependent Eligibility:	26	26	26	26	26	26	26
Rollover Benefit	No	No	No	No	Not Covered	Yes	Yes
Implant	Not Covered	Not Covered	Yes	Yes	Not Covered	Yes	Yes
Unique Locations General	2634	2634	219	219	221662	434	434
Provider Network	BCBS	BCBS	Delta DPO	Delta DPO	UHC DPPO	Guardian Preferred	Guardian Preferred
Rate Guarantee	24 Months	24 Months	24 Months	24 Months	12 Months w 7% 2nd year cap	24 Months	24 Months
4-Tier Monthly Rates							
Employee Only	$18.45	$43.75	$19.85	$47.08	$47.66	$18.86	$44.73
Employee + Spouse	$36.69	$93.48	$39.47	$100.58	$101.83	$37.50	$95.56
Employee + Children	$39.74	$84.74	$42.76	$91.18	$92.31	$40.62	$86.63
Employee + Family	$58.00	$157.90	$62.40	$169.90	$172.00	$59.29	$161.42
% Difference From Current		9.58%					
Notes: Lowering the Annual to 750/1500 will have a positive impact on rates of approximately 3%							

DENTON ISD		
DENTAL COMPARISON		
9/1/2017		
Carrier	Metlife	Metlife
	Proposed Low Plan	Proposed High Plan
Deductible / Family Max	$50 x All	$50 x All
Annual Maximum	$1,200	$2,000
Diagnostic & Preventive		
Reimbursement Percentage	90%	100%
Waiting Period	N/A	N/A
Basic Services		
Reimbursement Percentage	70%	80%
Waiting Period	12 Months / Late Entrant	N/A
Copay	$0	$0
Major Services		
Reimbursement Percentage	40%	50%
Waiting Period	12 Months / Late Entrant	N/A
Ortho Services		
Reimbursement Percentage	N/A	50%
Waiting Period	N/A	No Waiting Period
Eligibility	N/A	Under19
Lifetime Max.	N/A	$1,500
Network Reimbursement R&C		
In-network	Actual Charges	Actual Charges
Out-of-Network	MAC	90%
MISC		
Endo/Perio:	40%	80%
Dependent Eligibility:	26	26
Rollover Benefit	No	No
Implant	Not Covered	Not Covered
Unique Locations General	20964	20964
Provider Network	PDP	PDP
Rate Guarantee	12 Months / 6% yr 2 rate cap	12 Months / 6% yr 2 rate cap
4-Tier Monthly Rates		
Employee Only	$18.68	$44.34
Employee + Spouse	$37.15	$94.66
Employee + Children	$40.24	$85.81
Employee + Family	$58.73	$159.90
% Difference From Current	10.71%	10.78%
Notes: Lowering the Annual to 750/1500 will have a positive impact on rates of approximately 3%	1 year rate guaramtee with 6% cap on year 2. Proposed higher limits	1 year rate guaramtee with 6% cap on year 2. Proposed higher limits

Denton ISD Vision Comparison 9/1/2017	Recommended											
Carrier	Superior Low		Superior High		Cigna Low		Cigna High		Metlife Low		Metlife High	
Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Participation Requirement												
Exam - Co-Pay	$15	$10	$10	$15	$15	N/A - $45 Allowance	$10	N/A - $45 Allowance	$15	N/A - $45 Allowance	$10	N/A - $45 Allowance
Materials - Co-Pay	$20	$20	$20	$20	$20	N/A - $45 Allowance	$20	N/A - $45 Allowance	$20	N/A - $45 Allowance	$20	N/A - $45 Allowance
Contact Fitting Exam - Co-Pay	$25	N/A	$25	N/A	N/A	N/A - $45 Allowance	N/A	N/A - $45 Allowance	Max - $60	N/A - $45 Allowance	Max - $60	N/A - $45 Allowance
Exam / Materials - Frequency												
Exam:												
Allowance	Covered in Full	$42	Covered in Full	$42	Covered in Full	$42	Covered in Full	$42	Covered in Full	$42	Covered in Full	$42
Lens:												
Single Vision	Covered in Full	$26	Covered in Full	$26	Covered in Full	$32	Covered in Full	$32	Covered in Full	$32	Covered in Full	$32
Bifocal	Covered in Full	$34	Covered in Full	$34	Covered in Full	$55	Covered in Full	$55	Covered in Full	$55	Covered in Full	$55
Trifocal	Covered in Full	$50	Covered in Full	$50	Covered in Full	$65	Covered in Full	$65	Covered in Full	$65	Covered in Full	$65
Progressive	Covered in Full	$50	Covered in Full	$50	Covered at Bifocal amount with 20% discount on difference	Bifocal Amount	Covered at Bifocal amount with 20% discount on difference	Bifocal Amount	55 copay	Bifocal Amount	55 copay	Bifocal Amount
Polycarbonate	Covered in Full	Not Covered	Covered in Full	Not Covered	Covered for Children under 18	20% Discount	Covered for Children under 18	20% Discount	$35 Copay	20% Discount	$35 Copay	20% Discount
Frames												
Allowance	$125	$50	$150	$60	$130	$71	$150	$83	$125	$70	$150	$83
Medically Necessary Contact Lenses:												
Allowance	Covered in Full	N/A	Covered in Full	N/A	Covered in Full	$210	Covered in Full	$210	Covered in Full	$210	Covered in Full	$210
Elective Contact Lenses:												
Allowance	$150.00	up to $100	$150.00	up to $100	$150.00	$120.00	$150.00	$120.00	$125.00	$120.00	$150.00	$120.00
Lasik Benefit/Discount	Discounts available		Discounts available		Discounts available		Discounts available		Discounts available		Discounts available	
Unique Locations	95		95		1419		1419		2257		2257	
Provider Network	Superior		Superior		Vision PPO Plan		Vision Ppo Plan		Metlife Vision		Metlife Vision	
Rate Guarantee	48 Months		48 Months		24 Months		24 Months		24 Months		24 Months	
4-Tier Monthly Rates												
Employee Only	9.52		17.84		8.98		16.78		8.45		13.66	
Employee + Spouse	20.48		38.4		19.98		37.98		17.51		29.4	
Employee + Children	15.4		28.89		14.98		27.98		13.17		22.12	
Employee + Family	28.12		52.74		27.98		51.98		24.04		40.37	
Notes:	Only Carrier that has Walmart and Costco as true in network providers. All other carriers simply provide a discount when individual goes to Walmart to Costco. Also only carrier other than MES, that includes Luxottica (sports eyewear)		Plan includes both contact lenses and frames within the same 12 cycle. Only carrier that includes that.									

Denton ISD
Vision Comparison
9/1/2017

Carrier	Davis Vision Low		Davis Vision High		Avesis		Avesis		VSP Low		VSP High	
Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Participation Requirement												
Exam - Co-Pay	$15	N/A - $45 Allowance	$10	N/A - $45 Allowance	$10	N/A - $45 Allowance	$10	N/A - $45 Allowance	$15	$15	$15	$10
Materials - Co-Pay	$20	N/A - $45 Allowance	$20	N/A - $45 Allowance	$20	N/A - $45 Allowance	$20	N/A - $45 Allowance	$20	$20	$20	$20
Contact Fitting Exam - Co-Pay	$10	N/A - $45 Allowance	$10	N/A - $45 Allowance	$25	N/A - $45 Allowance	$25	N/A - $45 Allowance	$25	N/A	$25	N/A
Exam / Materials - Frequency												
Exam:												
Allowance	Covered in Full	Varies	Covered in Full	Varies	Covered in Full	Varies	Covered in Full	Varies	Covered in Full	Varies	Covered in Full	Varies
Lens:												
Single Vision	$20 Copay	$26	$20 Copay	$26	Covered in Full	$40	Covered in Full	$40	Covered in Full	$30	Covered in Full	$30
Bifocal	$20 Copay	$34	$20 Copay	$34	Covered in Full	$60	Covered in Full	$60	Covered in Full	$50	Covered in Full	$50
Trifocal	$20 Copay	$50	$20 Copay	$50	Covered in Full	$80	Covered in Full	$80	Covered in Full	$65	Covered in Full	$65
Progressive	$50 copay	$34	$50 Copay	$34	20% Discount	$40	Covered in full	$40	$55 Copay	$50	$55 Copay	$50
Polycarbonate	Covered in full for children w $0 copay / $30 Copay for adults	N/A	Covered in full for children w $0 copay / $30 Copay for adults	N/A	Covered in full Children / Not coevred for adults	$10	Covered in full for both children and adults	$10	Children - Covered in full, Adults in full after $30 copay	N/A	Covered in Full	N/A
Frames												
Allowance	$130	$50	$150	$60	$130	$50	$150	$65	$125	$70	$150	$70
Medically Necessary Contact Lenses:												
Allowance	Covered in Full	$225	Covered in Full	$225	Covered in Full	$250	Covered in Full	$250	Covered in Full	$210	Covered in Full	$210
Elective Contact Lenses:												
Allowance	$150.00	$100.00	$150.00	$100.00	$150.00	$110.00	$150.00	$130.00	$150.00	$105.00	$150.00	$105.00
Lasik Benefit/Discount	Discounts available		Discounts available		Discounts available		Discounts available		Discounts available		Discounts available	
Providers in 20 mile radius of 79029												
Unique Locations	556		556						78		78	
Provider Network	Davis Vision Exclusive		Davis Vision Exclusive		Avesis Network		Avesis Network		VSP		VSP	
Rate Guarantee	48 Months		48 Months		36 Months		36 Months		48 Months		48 Months	
4-Tier Monthly Rates												
Employee Only	7.04		11.44		8.54		11.7		8.2		11.92	
Employee + Spouse	15.14		24.62		15.34		20.44		16.42		23.82	
Employee + Children	11.39		18.53		16.72		21.54		17.56		25.48	
Employee + Family	20.79		33.82		22.66		28.86		28.08		40.74	
Notes:	Owns Vision Works but otherwise a very small network		Owns Vision Works but otherwise a very small network									

Denton ISD
Vision Comparison
9/1/2017

Carrier	MES Low		MES High		Eyemed		Eyemed	
Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-	In-Network	Out-of-
Participation Requirement								
Exam - Co-Pay	$15	$15	$15	$15	$15	$42	$10	$42
Materials - Co-Pay	$20	$20	$20	$20	$20	$26 to $50	$20	$26 to $50
Contact Fitting Exam - Co-Pay	$50 Benefit	N/A	$50 Benefit	N/A	$25	$40	$25	$40
Exam / Materials - Frequency								
Exam:								
Allowance	Covered in Full	Varies	Covered in Full	Varies	Covered in Full	Varies	Covered in Full	Varies
Lens:								
Single Vision	Covered in Full	$30	Covered in Full	$30	Covered in Full	$26	Covered in Full	$26
Bifocal	Covered in Full	$50	Covered in Full	$50	Covered in Full	$34	Covered in Full	$34
Trifocal	Covered in Full	$65	Covered in Full	$65	Covered in Full	$50	Covered in Full	$50
Progressive	$90	$65	$90	$65	$85 to $135 copay	$50	$85 to $135 copay	$50
Polycarbonate	$85	$55	$85	$55	$40 Copay	$40 Copay	0 Copay	$20 Copay
Frames								
Allowance	$125	$75	$150	$75	$125	$88	$175	$105
Medically Necessary Contact Lenses:								
Allowance	Covered in Full	$250	Covered in Full	$250	Covered in Full	$210	Covered in Full	$210
Elective Contact Lenses:								
Allowance	$150.00	Not Covered	$175.00	Not Covered	$150.00	$120.00	$175.00	$140.00
Lasik Benefit/Discount	Discounts available		Discounts available		Discounts available		Discounts available	
Providers in 20 mile radius of 79029								
Unique Locations	465		465		16		16	
Provider Network	MESVision		MESVISON		Insight		Insight	
Rate Guarantee	24 Months		24 Months		24 Months		24 Months	
4-Tier Monthly Rates								
Employee Only	7.83		8.76		7.53		14.27	
Employee + Spouse	14.1		15.77		16.19		30.71	
Employee + Children	13.79		15.42		12.18		23.1	
Employee + Family	20.21		22.61		22.23		42.17	
Notes:					Only MES and Superior carrier that has Luxottica (sports eyewear)		Only MES and Superior carrier that has Luxottica (sports eyewear)	

Denton ISD									
Base/Voluntary Life Comparison			RECOMMENDED						
9/1/2017									
	Current Plan	09/01 Effective	Proposed Plan	Proposed Plan	Proposed Plan	Proposed Plan	Proposed Plan	Proposed Plan	Proposed Plan
Carrier	Lincoln Financial	Lincoln Financial	One America	Voya	UNUM	Securian	Symetra	Metlife	Cigna
Base Life w/AD&D Comparison									
Base Per $15,000	**$0.69**	**$0.69**	**$0.83**	**$0.60**	**$0.60**	**$0.45**	**$0.51**	**$1.55**	**$1.35**
AD&D Per $15,000	**$0.32**	**$0.32**	**$0.15**	**$0.23**	**$0.23**	**$0.35**	**$0.30**	**$0.21**	**$0.30**
Total	**$1.01**	**$1.01**	**$0.98**	**$0.83**	**$0.83**	**$0.80**	**$0.81**	**$1.76**	**$1.65**
Base Life w/AD&D Comparison									
Base Per $1,000	**$0.046**	**$0.046**	**$0.055**	**$0.040**	**$0.040**	**$0.030**	**$0.034**	**$0.103**	**$0.090**
AD&D Per $1,000	**$0.021**	**$0.021**	**$0.010**	**$0.015**	**$0.015**	**$0.023**	**$0.020**	**$0.014**	**$0.020**
Total	**$0.067**	**$0.067**	**$0.065**	**$0.055**	**$0.055**	**$0.053**	**$0.054**	**$0.117**	**$0.110**
Voluntary Life w/AD&D Comparison									
Minimum Participation	25%	25%	N/A	25%	N/A	N/A	25%	25%	25%
Employee									
Benefit Increments	$10,000	$10,000	$10,000	$10,000	$10,000	$10,000	$10,000	$10,000	$10,000
Max. Times Salary	N/A	N/A	N/A	N/A	5x	N/A	5x	N/A	7x
Minimum	$10,000	$10,000	$10,000	$10,000	$10,000	$10,000	$10,000	$10,000	$10,000
Maximum	$500,000	$500,000	$500,000	$500,000	$500,000	$500,000	$500,000	$500,000	$500,000
***Guarantee Issue**	**$250,000**	**$250,000**	**$250,000**	**$250,000**	**$250,000**	**$250,000**	**$250,000**	**$250,000**	**$250,000**
Spouse									
Benefit Increments	$5,000	$5,000	$5,000	$10,000	$5,000	$5,000	$5,000	$5,000	$5,000
Benefit Amount Min/Max	50% of employee or 250,000	50% of employee or 250,000	50% of employee or 250,000	$250,000	50% of employee or 250,000	50% of employee or 250,000	50% of employee or 250,000	50% of employee or 250,000	50% of employee or 250,000
***Guarantee Issue**	**$50,000**	**$50,000**	**$50,000**	**$50,000**	**$50,000**	**$50,000**	**$50,000**	**$50,000**	**$50,000**
Children									
Benefit Increments	$10,000	$10,000	$10,000	$10,000	$10,000	$10,000	$10,000	$10,000	$10,000
Benefit Amount Min/Max	$10,000	$10,000	$10,000	$10,000	$10,000	$10,000	$10,000	$10,000	$10,000
***Guarantee Issue**	**$10,000**	**$10,000**	**$10,000**	**$10,000**	**$10,000**	**$10,000**	**$10,000**	**$10,000**	**$10,000**
Misc									
Age Reduction (applies to ee & sp)	None	None	None	None	None	None	None	None	65% at age 65, 35% at age 70,
Waiver of Premium	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Portability	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Conversion	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Accelerated Death Benefit	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Exclusions	2 Year Suicide	2 Year Suicide	2 Year Suicide	2 Year Suicide	2 Year Suicide	2 Year Suicide	2 Year Suicide	2 Year Suicide	2 Year Suicide
True or Modified Open Enrollment	N/A	N/A	Takeover	Takeover	Takeover	Takeover	Takeover	Takeover	Takeover
Electronic Application Available	No	No	No	No	No	No	No	No	No
Rate Guarantee (Voluntary)			**36 Months**	**36 Months**	**36 Months**	**36 Months**	**36 Months**	**36 Months**	**36 Months**
Employee	**Per $10,000**	**Per $10,000**	**Per $10,000**	**Per $10,000**	**Per $10,000**	**Per $10,000**	**Per $10,000**	**Per $10,000**	**Per $10,000**
< 25	$0.50	$0.70	.7	$0.70	0.67	.36	.5	.5	0.95
25-29	$0.50	$0.70	.7	$0.70	0.67	.36	.5	.53	0.95
30-34	$0.60	$0.80	.8	$0.80	0.76	.45	.6	.6	1.05
35-39	$0.90	$1.10	.9	$1.10	0.9	.54	.7	.68	1.15
40-44	$1.10	$1.30	1.30	$1.30	1.19	.91	1.1	.98	1.55
45-49	$1.50	$1.70	1.7	$1.70	1.61	1.28	1.5	1.28	1.95
50-54	$2.40	$2.60	2.6	$2.60	2.46	2.11	2.4	1.95	2.85
55-59	$3.70	$3.90	3.9	$3.90	3.68	3.3	3.7	2.93	4.15
60-64	$5.80	$6.00	6	$6.00	5.65	5.23	5.8	4.5	6.25
65-69	$11.40	$11.60	11.6	$11.60	10.92	10.39	11.4	8.7	11.85
70-74	$11.40	$11.60	11.6	$11.60	10.92	10.39	11.4	20.60	11.85
75-79									
80+									

Denton ISD									
Base/Voluntary Life Comparison			RECOMMENDED						
9/1/2017									
	Current Plan	09/01 Effective	Proposed Plan	Proposed Plan	Proposed Plan	Proposed Plan	Proposed Plan	Proposed Plan	Proposed Plan
Carrier	Lincoln Financial	Lincoln Financial	One America	Voya	UNUM	Securian	Symetra	Metlife	Cigna
Spouse	Per $10,000	Per $10,000	Per $10,000	Per $10,000	Per $10,000	Per $10,000	Per $10,000	Per $10,000	Per $10,000
< 25	$0.55	$0.80	.7	$0.70	0.67	.49	.6	.5	0.95
25-29	$0.55	$0.80	.7	$0.70	0.67	.49	.6	.53	0.95
30-34	$0.65	$0.90	.8	$0.80	0.76	.59	.7	.6	1.05
35-39	$0.75	$1.00	.9	$0.90	0.9	.69	.8	.68	1.15
40-44	$1.15	$1.40	1.30	$1.30	1.19	1.09	1.2	.98	1.55
45-49	$1.55	$1.80	1.7	$1.70	1.61	1.49	1.6	1.28	1.95
50-54	$2.45	$2.70	2.6	$2.60	2.46	2.39	2.5	1.95	2.85
55-59	$3.75	$4.00	3.9	$3.90	3.68	3.69	3.8	2.93	4.15
60-64	$5.85	$6.10	6	$6.00	5.65	5.79	5.9	4.5	6.25
65-69	$11.45	$11.70	11.6	$11.60	10.92	11.39	11.5	8.7	11.85
70-74	$11.45	$11.70	11.6	$11.60	10.92	11.39	11.5	20.60	11.85
75-79	$11.45	$11.70	11.6		10.92				0.25
80+	N/A	N/A							0.25
Dependent Child Rates	Per $10,000	Per $10,000	Per $10,000	Per $10,000	Per $10,000	Per $10,000	Per $10,000	Per $10,000	Per $10,000
Rate	$1.80	$1.80	$1.80	$1.80	$1.80	$1.80	$1.80	$1.73	$1.80
Per Child or Per Unit:	Unit	Unit	Unit	Unit	Unit	Unit	Unit	Unit	Unit
AD&D Rates	Per $10,000	Per $10,000	Per $10,000	Per $10,000	Per $10,000	Per $10,000	Per $10,000	Per $10,000	Per $10,000
Employee	$0.20	Included in VTL	Included in VTL	Included in VTL	Included in VTL	Included in VTL	Included in VTL	Included in VTL	Included in VTL
Spouse	$0.25	Included in VTL	Included in VTL	Included in VTL	Included in VTL	Included in VTL	Included in VTL	Included in VTL	Included in VTL
Child	N/A	Included in VTL	Included in VTL	Included in VTL	Included in VTL	Included in VTL	Included in VTL	Included in VTL	Included in VTL
Family	N/A	Included in VTL	Included in VTL	Included in VTL	Included in VTL	Included in VTL	Included in VTL	Included in VTL	Included in VTL
Notes:	Up until the FBS takeover this plan had been buil;t wrong. FBS realized that only the life insurance rate was being charged and not the AD&D rate. It is still built this way, however this will need to change beiginning 09/01 and will likely result in a rate increase for Denton ISD employees.	Up until the FBS takeover this plan had been buil't wrong. FBS realized that only the life insurance rate was being charged and not the AD&D rate. It is still built this way, however this will need to change beiginning 09/01 and will result in a rate increase for Denton ISD employees	Online EOI - EAP which includes 6 face to face visits, Will Prep, Legal Support, Financial Guidance	Includes an EAP with 3 telephonic and 6 face to face sessions, Also includes legal connect and travel assist		Includes eclaims, Financial and grief counseling and travel assistance			

Denton ISD				
Long Term/Short Term Disability Comparison			RECOMMENDED	
9/1/2017				
Carrier	**The Standard Plan A**	**The Standard Plan B**	**The Hartford Plan A**	**The Hartford Plan B**
Maximum Benefit Duration	**SSNRA**	**SSNRA / 3 year Illness**	**SSNRA**	**SSNRA / 3 year Illness**
Elimination Period(s)	**7,14,30,60,90,180**	**7,14,30,60,90,180**	**7,14,30,60,90,180**	**7,14,30,60,90,180**
Pre-Existing Provision	**3/12**	**3/12**	**3/12**	**3/12**
Pre Existing Benefit	**90 Days**	**90 Days**	**4 Week**	**4 Week**
Guarantee Issue Amount	**$8,000**	**$8,000**	**$8,000**	**$8,000**
Plan Features				
Monthly Benefit Maximum %	**66.67**	**66.67**	**66.67**	**66.67**
Monthly Benefit Minimum %	**$100**	**$100**	**$100**	**$100**
Partial Disability Benefit	**Yes**	**Yes**	**Yes**	**Yes**
Worksite Modification Benefit	**Yes**	**Yes**	**Yes**	**Yes**
Alcohol/Drug Benefit	**24 Months**	**24 Months**	**24 Months**	**24 Months**
Mental Illness/Self Reported Symptoms	**24 Months**	**24 Months**	**12 Months**	**12 Months**
Benefit Integration (Offsets)	**12 Months**	**12 Months**	**12 Months**	**12 Months**
Work Related Sickness or Injury	**N/A**	**N/A**	**N/A**	**N/A**
Waive the Elimination Period	**Under 30 EP**	**Under 30 EP**	**Under 30 EP**	**Under 30 EP**
Telephonic Claims Intake	**No**	**No**	**Yes**	**Yes**
Rate Guarantee			**36 Months**	**36 Months**
Plan Rating				
Rating Methodology	**Composite**	**Composite**	**Composite**	**Composite**
Premium Rate Per:	**200**	**200**	**200**	**200**
Cost per $200 Monthly Benefit				
0/7	$7.18	$5.28	$7.18	$5.28
14	$6.32	$4.32	$6.32	$4.32
30	$5.36	$3.54	$5.36	$3.54
60	$3.48	$2.90	$3.48	$2.90
90	$3.00	$2.42	$3.00	$2.42
180	$2.20	$1.82	$2.20	$1.82
Notes:	Includes EAP		Will Prep, Travel Assist, ID Theft, Healthcare support services. Pre-x only applies to those new to the plan. Anyone on the plan would not have to worry about that. Full takeover. EAP is also included with 3 face to face visits for all those on the plan. Can be provided to everyone not on the plan for .95 PEPM	Will Prep, Travel Assist, ID Theft, Healthcare support services. Pre-x only applies to those new to the plan. Anyone on the plan would not have to worry about that. Full takeover. EAP is also included with 3 face to face visits for all those on the plan. Can be provided to everyone not on the plan for .95 PEPM

Denton ISD				
Long Term/Short Term Disability Comparison				
9/1/2017				
Carrier	**Cigna Plan A**	**Cigna Plan B**	**One America Plan A**	**One America Plan B**
Maximum Benefit Duration	**SSNRA**	**SSNRA / 3 year Illness**	**SSNRA**	**SSNRA / 3 year Illness**
Elimination Period(s)	**7,14,30,60,90,180**	**7,14,30,60,90,180**	**7,14,30,60,90,180**	**7,14,30,60,90,180**
Pre-Existing Provision	**3/12**	**3/12**	**3/12**	**3/12**
Pre Existing Benefit	**90 Days**	**90 Days**	**No**	**No**
Guarantee Issue Amount	**$8,000**	**$8,000**	**$7,500**	**$7,500**
Plan Features				
Monthly Benefit Maximum %	**66.67**	**66.67**	**66.67**	**66.67**
Monthly Benefit Minimum %	**25%**	**25%**	**25%**	**25%**
Partial Disability Benefit	**Yes**	**Yes**	**Yes**	**Yes**
Worksite Modification Benefit	**Yes**	**Yes**	**Yes**	**Yes**
Alcohol/Drug Benefit	**24 Months**	**24 Months**	**24 Months**	**24 Months**
Mental Illness/Self Reported Symptoms	**24 Months**	**24 Months**	**24 Months**	**24 Months**
Benefit Integration (Offsets)	**12 Months**	**12 Months**	**12 Months**	**12 Months**
Work Related Sickness or Injury	**N/A**	**N/A**	**N/A**	**N/A**
Waive the Elimination Period	**Under 30 EP**	**Under 30 EP**	**Under 30 EP**	**Under 30 EP**
Telephonic Claims Intake	**Yes**	**Yes**	**Yes**	**Yes**
Rate Guarantee	**24 Months**	**24 Months**	**24 Months**	**24 Months**
Plan Rating				
Rating Methodology	**Composite**	**Composite**	**Composite**	**Composite**
Premium Rate Per:	**200**	**200**	**200**	**200**
Cost per $200 Monthly Benefit				
0/7	$11.48	$8.44	$8.24	$6.06
14	$10.12	$6.92	$7.26	$4.96
30	$8.58	$5.66	$6.16	$4.06
60	$5.56	$4.64	$3.98	$3.34
90	$4.80	$3.88	$3.44	$2.78
180	$3.52	$2.92	$2.52	$2.08
Notes:	Includes EAP (with 3 face to face visits), ID Theft, Will Prep, and hEalthy Rewards which is a discount program for a variety of health and wellness programs	Includes EAP (with 3 face to face visits), ID Theft, Will Prep, and hEalthy Rewards which is a discount program for a variety of health and wellness programs	Includes EAP	

Denton ISD		
Long Term/Short Term Disability Comparison		
9/1/2017		
Carrier	**UNUM Plan A**	**Unum Plan B**
Maximum Benefit Duration	**SSNRA**	**SSNRA / 3 year Illness**
Elimination Period(s)	**7,14,30,60,90,180**	**7,14,30,60,90,180**
Pre-Existing Provision	**3/12**	**3/12**
Pre Existing Benefit	**No**	**No**
Guarantee Issue Amount	**$8,000**	**$8,000**
Plan Features		
Monthly Benefit Maximum %	**66.67**	**66.67**
Monthly Benefit Minimum %	**25%**	**25%**
Partial Disability Benefit	**Yes**	**Yes**
Worksite Modification Benefit	**Yes**	**Yes**
Alcohol/Drug Benefit	**24 Months**	**24 Months**
Mental Illness/Self Reported Symptoms	**24 Months**	**24 Months**
Benefit Integration (Offsets)	**12 Months**	**12 Months**
Work Related Sickness or Injury	**N/A**	**N/A**
Waive the Elimination Period	**Under 30 EP**	**Under 30 EP**
Telephonic Claims Intake	**No**	**No**
Rate Guarantee	**24 Months**	**24 Months**
Plan Rating		
Rating Methodology	**Composite**	**Composite**
Premium Rate Per:	**200**	**200**
Cost per $200 Monthly Benefit		
0/7	$10.52	$8.50
14	$9.14	$7.20
30	$8.38	$6.28
60	$7.28	$4.94
90	$4.24	$2.74
180	$3.14	$1.96
Notes:	Includes EAP	

Denton ISD					
Cancer Comparison		RECOMMENDED			
9/1/2017					
Carrier	**Colonial / Current Plan**	**APL Low Plan / Proposed**	**APL High Plan / Proposed**	**Humana Proposed Low**	**Humana Proposed High**
Individual or Group Coverage?	Group	Group	Group	Group	Group
Application Required?	No	No	No	Yes, after year 1. GI Year 1.	Yes, after year 1. GI Year 1.
First Occurrence	$5,000.00	$5000 / 7500 (Dependent Children)	$10,000 / 15,000 (Dependent Children)	$2,500.00	$5,000.00
Radiation / Chemotherapy	$300 per day / Max 10k	$15,000	$20,000	$200 per day	$500 Per day
Experimental Treatment	$300 per day / max 10k	Covered like any other treatment	Covered like any other treatment	$7500 per year	$7500 per year
Wellness Screening Benefit	$100.00	$50 / $100 / $500 (Diagnostic, Follow up, Imaging)	$50 / $100 / $500 (Diagnostic, Follow up, Imaging)	$75.00	$100.00
Specified Disease Benefit	Included	N/A	N/A	Yes	Yes
Heart Attack / Stroke	N/A	$5000, $7500 (Dependent children	$10,000, $15,000 (Dependent children	N/A	N/A
ICU	$600 per day up to 180 days (combined with hospital confinement benefit)	$600 per day / $300 per day for step down unit	$600 per day / $300 per day for step down unit	$325 Per day	$625 Per day
Hospital Confinement	$300 Per day for first 30 days, $600 Per day after 30 days	N/A	N/A		N/A
Inpatient Surgery	$90 per unit up to $4500 per procedure	N/A	N/A	3,000.00	6,000.00
Attending Physician	$50 Per day	N/A	N/A	N/A	N/A
Ambulance	100.00	N/A	N/A	N/A	N/A
Patient transportation & lodging	$.40 up to 700 miles / $50 per day up to 70 days	N/A	N/A	$.50 per mile / $70 per day	$.50 per mile / $70 per day
Outpatient Surgery	$750 per day up to $2250 per year	N/A	N/A	N/A	N/A
Anesthesia	25% of Surgery benefit / $75 for local anesthesia	N/A	N/A	N/A	N/A
Breast Reconstruction	$90 per unit up to $4500 per procedure	N/A	N/A	N/A	N/A
Anti-Nausea	$50 a day / Max $200	N/A	N/A	N/A	N/A
Blood and Plasma	$300 per day / Max 10k	N/A	N/A	N/A	N/A
Prosthesis (hair, Breast)	$200 per calendar year	N/A	N/A	N/A	N/A
Hospice Care/Visits	$300 per day	N/A	N/A	N/A	N/A
Nursing	$300 per day	N/A	N/A	N/A	N/A
Stem cell/Bone Marrow transplant	$5,000 Per lifetime	N/A	N/A	N/A	N/A
Extended Care Facility	$300 Per day	N/A	N/A	N/A	N/A
Bone Marrow Transplant	$10,000 Per Lifetime	N/A	N/A	N/A	N/A
Waiver of Premium	Yes	Yes	Yes	Yes	Yes
Portability	Yes	Yes	Yes	Yes	Yes
Base Rates					
Individual	$29.85	$17.46	$26.80	$17.22	$32.06
Employee and Spouse	$49.55	$37.14	$57.60	$36.67	$66.90
Single Parent	$49.55	$22.20	$33.00	$36.67	$66.90
Family	$49.55	$41.88	$63.84	$36.67	$66.90
Additional Riders					
Notes:		GI every year - Includes Criticall Illness Plan	GI every year - Includes Criticall Illness Plan	Not GI After 1st year.	Not GI After 1st year.