Town of Juno Beach
Medical RFP Renewal Evaluation
Effective Date: January 1, 2024

RISK strategies | GEHRING GROUP A RISK STRATEGIES COMPANY

	PPO	HMO	CURRENT PPO Plan Florida Blue BlueOptions 18153		CURRENT HMO Plan Florida Blue BlueCare 14354	RENEWAL PPO Plan Florida Blue BlueOptions 18153		RENEWAL HMO Plan Florida Blue BlueCare 14354
			In-Network	Out-of-Network	In-Network Only	In-Network	Out-of-Network	In-Network Only
Calendar Year Deductible (CYD)			BlueOptions		BlueCare	BlueOptions		BlueCare
Single			$1,700	$3,400	$1,750	$1,800	$3,600	$1,750
Family			$3,400	$6,800	$3,500	$3,600	$7,200	$3,500
Out of Pocket Maximum			Includes All Costs		Includes All Costs	Includes All Costs		Includes All Costs
Single			$3,700	$7,400	$5,300	$3,700	$7,400	$5,300
Family			$7,400	$14,800	$10,600	$7,400	$14,800	$10,600
Coinsurance (Member)			10%	50%	20%	10%	50%	20%
Non-Hospital Services								
Primary Care Physician			VCP: $0/ CYD + 10%	CYD + 50%	VCP: $0/PCP: $20 Copay	VCP: $0/ CYD + 10%	CYD + 50%	VCP: $0/PCP: $20 Copay
Telemedicine			No Charge / CYD + 10%	Not Covered	No Charge / $50 Copay	No Charge / CYD + 10%	Not Covered	No Charge / $50 Copay
Specialist			VCP: $20 / CYD + 10%	CYD + 50%	VCP: $20 / $50 Copay	VCP: $20 / CYD + 10%	CYD + 50%	VCP: $20 / $50 Copay
Preventive Services			No Charge	50%	No Charge	No Charge	50%	No Charge
Laboratory Services / X-Ray Services			VCP: $20 / ICL: $35 / IDTC: CYD + 10%	CYD + 50%	VCP: $20 / ICL: $50 / IDTC: CYD + 20%	VCP: $20 / ICL: $35 / IDTC: CYD + 10%	CYD + 50%	VCP: $20 / ICL: $50 / IDTC: CYD + 20%
Advanced Imaging - CT, PET, MRI			CYD + 10%	CYD + 50%	CYD + 20%	CYD + 10%	CYD + 50%	CYD + 20%
Urgent Care Center			VCP: $0 1-2 Visits/CYD + 10%	CYD + 10%	VCP: $0 1-2 Visits/$55	VCP: $0 1-2 Visits/CYD + 10%	CYD + 10%	VCP: $0 1-2 Visits/$55
Hospital Services								
Inpatient			CYD + 10%	CYD + 50%	CYD + 20%	CYD + 10%	CYD + 50%	CYD + 20%
Outpatient			CYD + 10%	CYD + 50%	ASC: 20%/Hosp: CYD + 20%	CYD + 10%	CYD + 50%	ASC: 20%/Hosp: CYD + 20%
Physician Services - Inpatient			CYD + 10%	INN CYD + 10%	$100 Copay	CYD + 10%	INN CYD + 10%	$100 Copay
Physician Services - Outpatient			CYD + 10%	INN CYD + 10%	$100 Copay	CYD + 10%	INN CYD + 10%	$100 Copay
Emergency Room			CYD + 10%	INN CYD + 10%	CYD + 20%	CYD + 10%	INN CYD + 10%	CYD + 20%
Mental Health/Substance Abuse								
Inpatient Services (At Hospital)			CYD + 10%	CYD + 10%	No Charge	**No Charge**	CYD + 10%	No Charge
Outpatient Office Visit (At Provider's Office			No Charge	CYD + 50%	No Charge	No Charge	CYD + 50%	No Charge
Outpatient (Other Services)			CYD + 10%	CYD + 50%	No Charge	**No Charge**	CYD + 50%	No Charge
Prescription Drug Benefit			*Condition Care Rx - $4/$15		*Condition Care Rx - $4,$14/$15,$35	*Condition Care Rx - $4/$15		*Condition Care Rx - $4,$14/$15,$35
Tier 1			CYD + $10	Not Covered	$10/$20	CYD + $10	Not Covered	$10/$20
Tier 2			CYD + $30		$30/$40	CYD + $30		$30/$40
Tier 3			CYD + $50		$50/$70	CYD + $50		$50/$70
Tier 4			N/A		N/A	N/A		N/A
Specialty Drugs			CYD + $150		$150	CYD + $150		$150
Mail-Order Drugs (90-Day Supply)			CYD + 2x Copay		2x Copay	CYD + 2x Copay		2x Copay
Rates	PPO	HMO						
Employee	0	12	**$908.70**		**$760.44**	**$946.67**		**$812.61**
Employee + Spouse	0	6	**$1,817.41**		**$1,520.87**	**$1,893.34**		**$1,625.22**
Employee + Child(ren)	0	0	**$1,681.10**		**$1,406.81**	**$1,751.34**		**$1,503.33**
Employee + Family	1	6	**$2,589.81**		**$2,167.25**	**$2,698.01**		**$2,315.95**
Annual Total Cost	1	24	**$31,077.72**		**$375,048.00**	**$32,376.12**		**$400,780.08**
Aggregate Total	25		**$406,125.72**			**$433,156.20**		
$ Increase			**N/A**			**$27,030.48**		
% Increase			**N/A**			**6.7%**		

VCP=Value Choice Provider
NP=Network Provider

***Covers Preventive Generic** (Current)

***Covers Preventive Generic** (Renewal)

Town of Juno Beach
Medical RFP Renewal Evaluation
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RISK strategies | GEHRING GROUP — A RISK STRATEGIES COMPANY

			CURRENT			ALTERNATIVE #1		
			PPO Plan Florida Blue BlueOptions 18153		HMO Plan Florida Blue BlueCare 14354	PPO Plan Florida Blue BlueOptions Predictable Cost 18052		HMO Plan Florida Blue BlueCare 14353
			In-Network	Out-of-Network	In-Network Only	In-Network	Out-of-Network	In-Network Only
Calendar Year Deductible (CYD)			**BlueOptions**		**BlueCare**	**BlueOptions**		**BlueCare**
Single			$1,700	$3,400	$1,750	$1,800	$3,600	$2,000
Family			$3,400	$6,800	$3,500	$3,600	$7,200	$4,000
Out of Pocket Maximum			**Includes All Costs**		**Includes All Costs**	**Includes All Costs**		**Includes All Costs**
Single			$3,700	$7,400	$5,300	$8,600	$17,200	$4,500
Family			$7,400	$14,800	$10,600	$17,200	$34,400	$9,000
Coinsurance (Member)			10%	50%	20%	50%	50%	20%
Non-Hospital Services								
Primary Care Physician			VCP: $0/ CYD + 10%	CYD + 50%	VCP: $0/PCP: $20 Copay	VCP: $0/ $50	CYD + 50%	VCP: $0/PCP: $35 Copay
Telemedicine			No Charge / CYD + 10%	Not Covered	No Charge / $50 Copay	No Charge / $85	Not Covered	No Charge / $60 Copay
Specialist			VCP: $20 / CYD + 10%	CYD + 50%	VCP: $20 / $50 Copay	VCP: $20/ $85	CYD + 50%	VCP: $20 / $60 Copay
Preventive Services			No Charge	50%	No Charge	No Charge	50%	No Charge
Laboratory Services / X-Ray Services			VCP: $20 / ICL: $35 / IDTC: CYD + 10%	CYD + 50%	VCP: $20 / ICL: $50 / IDTC: CYD + 20%	VCP: $20 / ICL: $15 / IDTC: $150	CYD + 50%	VCP: $20 / ICL: $50 / IDTC: CYD + 20%
Advanced Imaging - CT, PET, MRI			CYD + 10%	CYD + 50%	CYD + 20%	$300	CYD + 50%	CYD + 20%
Urgent Care Center			VCP: $0 1-2 Visits/CYD + 10%	CYD + 10%	VCP: $0 1-2 Visits/$55	VCP: $0 1-2 Visits/$50	CYD + $50	VCP: $0 1-2 Visits/$65
Hospital Services								
Inpatient			CYD + 10%	CYD + 50%	CYD + 20%	CYD + 50%	CYD + 50%	CYD + 20%
Outpatient			CYD + 10%	CYD + 50%	ASC: 20%/Hosp: CYD + 20%	CYD + 50%	CYD + 50%	ASC: 20%/Hosp: CYD + 20%
Physician Services - Inpatient			CYD + 10%	INN CYD + 10%	$100 Copay	CYD + 50%	INN CYD + 50%	$100 Copay
Physician Services - Outpatient			CYD + 10%	INN CYD + 10%	$100 Copay	CYD + 50%	INN CYD + 50%	$100 Copay
Emergency Room			CYD + 10%	INN CYD + 10%	CYD + 20%	$700	$700	CYD + 20%
Mental Health/Substance Abuse								
Inpatient Services (At Hospital)			CYD + 10%	CYD + 10%	No Charge	No Charge	CYD	No Charge
Outpatient Office Visit (At Provider's Office			No Charge	CYD + 50%	No Charge	No Charge	CYD + 50%	No Charge
Outpatient (Other Services)			CYD + 10%	CYD + 50%	No Charge	No Charge	CYD + 50%	No Charge
Prescription Drug Benefit			*Condition Care Rx - $4/$15		*Condition Care Rx - $4,$14/$15,$35	*Condition Care Rx Retail - $4/$30		*Condition Care Rx - $4,$14/$15,$35
Tier 1			CYD + $10	Not Covered	$10/$20	$15	Not Covered	$10/$20
Tier 2			CYD + $30		$30/$40	Pharmacy Deductible ($5,000) + 50%		$30/$40
Tier 3			CYD + $50		$50/$70			$50/$70
Tier 4			N/A		N/A			N/A
Specialty Drugs			CYD + $150		$150			$150
Mail-Order Drugs (90-Day Supply)			CYD + 2x Copay		2x Copay	2x Retail (Generic/condition Care)		2x Copay
Rates	**PPO**	**HMO**						
Employee	0	12	$908.70		$760.44	$852.04		$811.11
Employee + Spouse	0	6	$1,817.41		$1,520.87	$1,704.08		$1,622.21
Employee + Child(ren)	0	0	$1,681.10		$1,406.81	$1,576.27		$1,500.55
Employee + Family	1	6	$2,589.81		$2,167.25	$2,428.31		$2,311.65
Annual Total Cost	1	24	$31,077.72		$375,048.00	$29,139.72		$400,037.76
Aggregate Total	25		$406,125.72			$429,177.48		
$ Increase			N/A			$23,051.76		
% Increase			N/A			5.7%		

VCP=Value Choice Provider
NP=Network Provider

*Covers Preventive Generic

*Covers Preventive Generic

Town of Juno Beach
Medical RFP Renewal Evaluation
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RISK strategies | GEHRING GROUP — A RISK STRATEGIES COMPANY

	CURRENT			ALTERNATIVE #2		
	PPO Plan Florida Blue BlueOptions 18153		HMO Plan Florida Blue BlueCare 14354	NHP POS UnitedHealthcare UHC Choice Plus HSA Gold 1600 DIG4 L27 S		HMO Plan UnitedHealthcare UHC Choice Gold 2000 CWAA L27 S
	In-Network	Out-of-Network	In-Network Only	In-Network	Out-of-Network	In-Network Only
Calendar Year Deductible (CYD)	**BlueOptions**		**BlueCare**	**POS Plan**		**Choice HMO Plan**
Single	$1,700	$3,400	$1,750	$1,600	$3,000	$2,000
Family	$3,400	$6,800	$3,500	$3,200	$6,000	$2,000/4000
Out of Pocket Maximum	Includes All Costs		Includes All Costs	Includes All Costs		Includes All Costs
Single	$3,700	$7,400	$5,300	$7,000	$12,000	$6,000
Family	$7,400	$14,800	$10,600	$8,550	$24,000	$6,000/12000
Coinsurance (Member)	10%	50%	20%	20%	40%	20%
Non-Hospital Services						
Primary Care Physician	VCP: $0/ CYD + 10%	CYD + 50%	VCP: $0/PCP: $20 Copay	CYD + 20%	CYD + 40%	$25
Telemedicine	No Charge / CYD + 10%	Not Covered	No Charge / $50 Copay	No Charge / No Charge	CYD + 40%	No Charge / No Charge
Specialist	VCP: $20 / CYD + 10%	CYD + 50%	VCP: $20 / $50 Copay	CYD + 20%	CYD + 40%	$80
Preventive Services	No Charge	50%	No Charge	No Charge	CYD + 40%	No Charge
Laboratory Services / X-Ray Services	VCP: $20 / ICL: $35 / IDTC: CYD + 10%	CYD + 50%	VCP: $20 / ICL: $50 / IDTC: CYD + 20%	ICL DDP: CYD + 20% / ICL NDDP: CYD + 50% / IDTC: CYD +20%	CYD + 40%	ICL DPP:CYD + 20% / NDDP:CYD + 50% / IDTC:CYD +20%
Advanced Imaging - CT, PET, MRI	CYD + 10%	CYD + 50%	CYD + 20%	DDP:CYD + 20% / NDDP: $500 POD + CYD + 50%	$500 POD + CYD + 40%	DDP: $400 / NDDP: $500 POD + CYD +50%
Urgent Care Center	VCP: $0 1-2 Visits/CYD + 10%	CYD + 10%	VCP: $0 1-2 Visits/$55	CYD + 20%	CYD + 40%	$50 Copay
Hospital Services						
Inpatient	CYD + 10%	CYD + 50%	CYD + 20%	CYD + 20%	CYD + 40%	$500 + CYD + 20%
Outpatient	CYD + 10%	CYD + 50%	ASC: 20%/Hosp: CYD + 20%	CYD + 20%	CYD + 40%	ASC: $250 + CYD + 20% /
Physician Services - Inpatient	CYD + 10%	INN CYD + 10%	$100 Copay	CYD + 20%	CYD + 40%	CYD + 20%
Physician Services - Outpatient	CYD + 10%	INN CYD + 10%	$100 Copay	CYD + 20%	CYD + 40%	CYD + 20%
Emergency Room	CYD + 10%	INN CYD + 10%	CYD + 20%	CYD + 20%	CYD + 20%	CYD + 20%
Mental Health/Substance Abuse						
Inpatient Services (At Hospital)	CYD + 10%	CYD + 10%	No Charge	CYD + 20%	CYD + 40%	CYD + 20%
Outpatient Office Visit (At Provider's Office	No Charge	CYD + 50%	No Charge	CYD + 20%	CYD + 40%	$25
Outpatient (Other Services)	CYD + 10%	CYD + 50%	No Charge	CYD + 20%	CYD + 20%	CYD +20%
Prescription Drug Benefit	*Condition Care Rx - $4/$15		*Condition Care Rx - $4,$14/$15,$35			
Tier 1	CYD + $10	Not Covered	$10/$20	CYD + $10	CYD + $10	$10
Tier 2	CYD + $30		$30/$40	CYD + $40	CYD + $40	$40
Tier 3	CYD + $50		$50/$70	CYD + $150	CYD + $150	$150
Tier 4	N/A		N/A	CYD + $300	CYD + $300	$300
Specialty Drugs	CYD + $150		$150	CYD+P:$10/$40/$150/$500 CYD+NP:$20/$80/$300/$1,000	Not Covered	P:$10/$40/$150/$500 NP:$20/$80/$300/$1,000
Mail-Order Drugs (90-Day Supply)	CYD + 2x Copay		2x Copay	CYD + 2.5x Copay		2.5x Copay
Rates (PPO / HMO)						
Employee (0 / 12)	$908.70		$760.44	$1,030.95		$1,034.86
Employee + Spouse (0 / 6)	$1,817.41		$1,520.87	$2,061.90		$2,069.71
Employee + Child(ren) (0 / 0)	$1,681.10		$1,406.81	$1,907.26		$1,914.48
Employee + Family (1 / 6)	$2,589.81		$2,167.25	$2,938.21		$2,949.34
Annual Total Cost (1 / 24)	$31,077.72		$375,048.00	$35,258.52		$510,391.44
Aggregate Total (25)	$406,125.72			$545,649.96		
$ Increase	N/A			$139,524.24		
% Increase	N/A			34.4%		

VCP=Value Choice Provider
NP=Network Provider

***Covers Preventive Generic**

Town of Juno Beach
Dental PPO RFP Renewal Evaluation
Effective Date: January 1, 2024

SCHEDULE OF BENEFITS			CURRENT Solstice Base Plan 11027		CURRENT Solstice Buy-Up Plan 11431		RENEWAL Solstice Base Plan 11027		RENEWAL Solstice Buy-Up Plan 11431	
			In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Basics										
Annual Benefit Maximum			$2,000*		$2,500*		$2,000*		$2,500*	
Deductibles										
Single			$50	$50	$25	$25	$50	$50	$25	$25
Family			$150	$150	$75	$75	$150	$150	$75	$75
Deductible Waived for Preventive & Diagnostic Services			Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Benefits										
Preventive			100%	100%	100%	100%	100%	100%	100%	100%
Basic			90%	80%	100%	80%	90%	80%	100%	80%
Major			60%	50%	60%	50%	60%	50%	60%	50%
Orthodontic Services			50%	50%	50%	50%	50%	50%	50%	50%
Service Information										
Out-of-Network Reimbursement			Fee Schedule		90% R&C		Fee Schedule		90% R&C	
Waiting Period			None		None		None		None	
Orthodontic Maximum			$1,000		$1,500		$1,000		$1,500	
Orthodontic Coverage			Child Only Ortho		Adult & Child Ortho		Child Only Ortho		Adult & Child Ortho	
Endodontics / Periodontics			Basic		Basic		Basic		Basic	
Rate Guarantee			**Expires 12/31/2023**		**Expires 12/31/2023**		**Expires 12/31/2024**		**Expires 12/31/2024**	
Rates	11027	11431								
Employee	**14**	**2**	**$30.73**		**$49.11**		**$30.73**		**$49.11**	
Employee + Spouse	**8**	**1**	**$61.49**		**$98.21**		**$61.49**		**$98.21**	
Employee + Child(ren)	**2**	**0**	**$79.53**		**$126.62**		**$79.53**		**$126.62**	
Employee + Family	**6**	**2**	**$108.54**		**$173.38**		**$108.54**		**$173.38**	
Monthly Premium	**30**	**5**	**$1,732.44**		**$543.19**		**$1,732.44**		**$543.19**	
Annual Premium	**35**		**$20,789.28**		**$6,518.28**		**$20,789.28**		**$6,518.28**	
Aggregate Total			**$27,307.56**				**$27,307.56**			
$ Increase/Decrease			**N/A**				**$0.00**			
% Increase/Decrease			**N/A**				**0.0%**			

*Includes BenefitsBooster Benefit (Current Base Plan 11027)
*Includes BenefitsBooster Benefit (Current Buy-Up Plan 11431)
*Includes BenefitsBooster Benefit (Renewal Base Plan 11027)
*Includes BenefitsBooster Benefit (Renewal Buy-Up Plan 11431)

Town of Juno Beach
Dental PPO RFP Renewal Evaluation
Effective Date: January 1, 2024

			CURRENT				ALTERNATIVE #1			
SCHEDULE OF BENEFITS			Solstice Base Plan 11027		Solstice Buy-Up Plan 11431		Humana FL PPO 01K INFS+		Humana FL PPO 01.5K INFS+	
			In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Basics										
Annual Benefit Maximum			$2,000*		$2,500*		$2,000*		**Unlimited**	
Deductibles										
Single			$50	$50	$25	$25	$50	$50	$25	**$50**
Family			$150	$150	$75	$75	$150	$150	$75	**$150**
Deductible Waived for Preventive & Diagnostic Services			Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Benefits										
Preventive			100%	100%	100%	100%	100%	100%	100%	100%
Basic			90%	80%	100%	80%	90%	80%	100%	80%
Major			60%	50%	60%	50%	60%	50%	60%	50%
Orthodontic Services			50%	50%	50%	50%	50%	50%	50%	50%
Service Information										
Out-of-Network Reimbursement			Fee Schedule		90% R&C		MAC		MAC	
Waiting Period			None		None		None		None	
Orthodontic Maximum			$1,000		$1,500		$1,000		$1,500	
Orthodontic Coverage			Child Only Ortho		Adult & Child Ortho		**Adult** & Child Ortho		Adult & Child Ortho	
Endodontics / Periodontics			Basic		Basic		Basic		Basic	
Rate Guarantee			**Expires 12/31/2023**		**Expires 12/31/2023**		**Expires 12/31/2024**		**Expires 12/31/2024**	
Rates	11027	11431								
Employee	**14**	**2**	**$30.73**		**$49.11**		**$41.07**		**$47.24**	
Employee + Spouse	**8**	**1**	**$61.49**		**$98.21**		**$82.15**		**$94.49**	
Employee + Child(ren)	**2**	**0**	**$79.53**		**$126.62**		**$110.21**		**$128.56**	
Employee + Family	**6**	**2**	**$108.54**		**$173.38**		**$152.78**		**$178.05**	
Monthly Premium	**30**	**5**	**$1,732.44**		**$543.19**		**$2,369.28**		**$545.07**	
Annual Premium	**35**		**$20,789.28**		**$6,518.28**		**$28,431.36**		**$6,540.84**	
Aggregate Total			**$27,307.56**				**$34,972.20**			
$ Increase/Decrease			**N/A**				**$7,664.64**			
% Increase/Decrease			**N/A**				**28.1%**			

*Includes BenefitsBooster Benefit

*Includes BenefitsBooster Benefit

*Includes extended annual max-30%

Town of Juno Beach
Life & Disability Renewal Evaluation
Effective Date: January 1, 2024

RISK strategies | GEHRING GROUP A RISK STRATEGIES COMPANY

	CURRENT	RENEWAL
Basic Life with AD&D	**The Standard**	**The Standard**
Class Description		
Class 1	All FT Active EE's Working at least 25 Hours per Week	All FT Active EE's Working at least 25 Hours per Week
Class 2	Retired employees who are at least 52 years of age or a Retired employee who has 25 years or more of service	Retired employees who are at least 52 years of age or a Retired employee who has 25 years or more of service
Features		
Death Benefit	Class 1: $50,000 / Class 2: $50,000	Class 1: $50,000 / Class 2: $50,000
Waiver of Premium	Class 1: Included / Class 2: Not Included	Class 1: Included / Class 2: Not Included
Accelerated Death Benefit	Class 1: Included / Class 2: Not Included	Class 1: Included / Class 2: Not Included
Age Reduction Schedule (to)	65% at age 65 / 40% at age 70 / 20% at age 75	65% at age 65 / 40% at age 70 / 20% at age 75
Rate Guarantee Period	**Expires 12/31/2025**	**Expires 12/31/2025**
Cost		
Basic Life Rate / $1,000	**$0.270**	**$0.270**
AD&D Rate / $1,000	**$0.020**	**$0.020**
Estimated Volume	**$1,622,500**	**$1,622,500**
Retiree Volume	**$125,000**	**$125,000**
Total Monthly Premium	**$504.28**	**$504.28**
Total Annual Premium	**$6,051.30**	**$6,051.30**
$ Increase	**N/A**	**$0.00**
% Increase	**N/A**	**0.0%**
Short Term Disability- Employer Paid	**The Standard**	**The Standard**
All Eligible Employees	All FT Active EE's Working at least 25 Hours per Week	All FT Active EE's Working at least 25 Hours per Week
Elimination Period	7 Days	7 Days
Benefit Percent	60%	60%
Maximum Weekly Benefit	$1,200	$1,200
Duration of Benefit	173 days	173 days
Rate Guarantee Period	**Expires 12/31/2025**	**Expires 12/31/2025**
Cost		
STD Rate / $10	**$0.263**	**$0.263**
Estimated Volume	**$28,081**	**$28,081**
Monthly Premium	**$738.53**	**$738.53**
Annual Premium	**$8,862.36**	**$8,862.36**
$ Increase	**N/A**	**$0.00**
% Increase	**N/A**	**0.0%**
Long Term Disability- Employer Paid	**The Standard**	**The Standard**
All Eligible Employees	All FT Active EE's Working at least 25 Hours per Week	All FT Active EE's Working at least 25 Hours per Week
Elimination Period	180 Days	180 Days
Own Occupation Period	2 Years	2 Years
Duration of Benefit	SSNRA	SSNRA
Disability Percentage Benefit	60%	60%
Maximum Monthly Benefit	$6,000	$6,000
Rate Guarantee Period	**Expires 12/31/2025**	**Expires 12/31/2025**
Cost		
LTD Rate / $100	**$0.231**	**$0.231**
Estimated Volume	**$209,166**	**$209,166**
Monthly Premium	**$483.17**	**$483.17**
Annual Premium	**$5,798.08**	**$5,798.08**
$ Increase	**N/A**	**$0.00**
% Increase	**N/A**	**0.00%**
Grand Total Monthly Premium	**$1,725.98**	**$1,725.98**
Grand Total Annual Premium	**$20,711.75**	**$20,711.75**
$ Increase	**N/A**	**$0.00**
% Increase	**N/A**	**0.0%**

EAP Included