Skynet Healthcare Technologies

Benefits Election Form

Effective March 1, 2018

	Dental Plan Option #1 **Guardian** *PPO without Orthodontia*		***Dental Plan Option #2*** **Guardian** *PPO with Orthodontia*	
Key Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Calendar Year Deductible	***$50 Single*** ***up to $150 Family***	$100 Single up to $300 Family	***$50 Single*** ***up to $150 Family***	$100 Single up to $300 Family
Preventive Services	deductible waived	deductible applies	deductible waived	deductible applies
exams/cleanings	0% member cost	20% member cost	0% member cost	10% member cost
x-rays	0%	20%	0%	10%
fluoride treatment	0%	20%	0%	10%
Basic Services	deductible applies		deductible applies	
fillings	20% member cost	30% member cost	***0% member cost***	30% member cost
periodontics	20%	30%	0%	30%
endodontics	**50%**	**40%**	40%	**40%**
Major Services	deductible applies		deductible applies	
inlays, onlays, crowns	50% member cost	60% member cost	40% member cost	60% member cost
bridges	50%	60%	40%	60%
Calendar Year Maximum	$1,000 benefit / insured		***$1,500 benefit / insured***	
Orthodontia (child only)	not included	not included	***50% member cost*** $1,000 lifetime maximum	***50% member cost***
Reimbursement Schedule	fee schedule	in-network fee schedule (may be balance billed)	fee schedule	in-network fee schedule (may be balance billed)

If there are any discrepancies between this summary and the Master Contract, then the Master Contract will control.

Coverage Status		**Option #1 Per Pay Deduction**		**Option #2 Per Pay Deduction**
Single	0	$9.80	0	$13.06
Parent Child/ren	0	$26.58	0	$38.73
Husband Wife	0	$21.97	0	$29.27
Family	0	$36.03	X	$51.84

I elect to DECLINE Coverage and understand that I may not enroll until next Open Enrollment unless I experience a loss of other dental coverage: 0

Luther G Barnum Jr — Jan 31, 2018

Employee Name: **Employee Signature:** **Date:**

Skynet Healthcare Technologies

Benefits Election Form

Effective March 1, 2018

	Vision Plan Benefits **Guardian** *Davis Vision Network*	
Key Benefits	**In-Network**	**Out-of-Network**
Benefit Frequency	Exams: Once per Calendar Year Lenses: Once per Calendar Year Frames: Once every other Calendar Year	
Eye Exam	$10 copay	$10 + $50 reimbursement
Base Lenses		
Single Vision	$25 copay	$48 reimbursement
Bifocal Vision	$25 copay	$67 reimbursement
Trifocal Vision	$25 copay	$86 reimbursement
Lenticular Vision	$25 copay	$126 reimbursement
Contact Lenses	(in lieu of eyeglass lenses)	
Elective Lenses	$130 allowance	$105 reimbursement
Frames	$130 allowance	$48 reimbursement

Additional Benefits **Guardian** *Life & Disability*	
Life Benefit:	Flat $25,000 Benefit Age Reductions: 35% @ age 65 60% @ age 70, etc.
Long-Term Disability Benefit:	60% of monthly salary Up to $6,000/month benefit 90-day waiting period Benefits paid until age 67 or social security retirement age

If there are any discrepancies between this summary and the Master Contract, then the Master Contract will control.

Coverage Status		**Vision Per Pay Deduction**
Single	0	$2.62
Parent Child/ren	0	$4.48
Husband Wife	0	$4.39
Family	X 0	$7.09

Life & Disability
Company Paid - NO Payroll Deductions
All employees must elect coverage.

I elect to DECLINE Coverage and understand that I may not enroll until next Open Enrollment unless I experience a loss of other vision coverage:	0

Luther G Barnum Jr — **Employee Name:**

Luther G Barnum — **Employee Signature:**

Feb 2, 2018 — **Date:**