Benefits that Work as Hard as You Do

Dental & Vision Benefits Guide - Georgia Brochure

Offered by:

GRIFFIN & COMPANY INSURANCE

KEYSTONE®

When it comes to benefits, one size does not fit all.

We understand that you work for so much more than a paycheck. You work for your future, for your home and for your family—and you need benefits that work as hard as you do.

When it comes to taking care of you and your family, insurance is a must. Creating a solid foundation with dental and medical coverage, combined with healthcare savings, is the best way to help keep them well protected. With access to one of the nation's largest dental & vision networks, we can provide benefits that are flexible to fit your life.

Find out how MetLife can benefit you today!

Underwritten by:

MetLife

Dental Plan Benefits & Rates

(Rates valid 1/1/18 to 12/31/18)

	PLATINUM DENTAL PLAN
	100/80/50, $1,500 Annual Max with $1,000 Child Orthodontia
Deductible (waived for preventative)	$50 per person / $150 per family
Annual Maximum	$1,500
Preventive Care *Cleanings, exams, bitewing x-rays*	100%
Basic Services *Composite fillings, sealants, space maintainers*	80%
Major Services *Crowns, bridges, dentures, implants*	50%
Orthodontics *Lifetime maximum*	Child Only, 50% to $1,000
Endodontics & Periodontics	Covered in Major Services
Benefit Waiting Period *(Applies to Voluntary Plan or less than 10 eligible lives)*	12 Months for Major and Orthodontic Services
Out of Network Reimbursement	90th Reasonable & Customary

Monthly Rates by Region	6	7	8	9	10	12
Employer Sponsored						
Employee Only	$28.94	$30.89	$33.39	$36.18	$39.21	$46.39
Employee + Spouse	$58.92	$62.89	$67.98	$73.65	$79.81	$94.41
Employee + Child(ren)	$69.02	$73.37	$78.76	$86.28	$92.87	$108.40
Employee + Spouse + Child(ren)	$106.56	$113.38	$121.90	$132.89	$143.26	$167.77
Voluntary (or groups with less than 10 eligible lives)						
Employee Only	$32.67	$34.87	$37.69	$40.84	$44.27	$52.37
Employee + Spouse	$66.52	$71.00	$76.74	$83.15	$90.10	$106.58
Employee + Child(ren)	$77.15	$82.06	$88.14	$96.44	$103.88	$121.41
Employee + Spouse + Child(ren)	$119.36	$127.06	$136.68	$148.89	$160.60	$188.27

Georgia	Zip Code
Region 6	313, 314, 318, 319
Region 7	310,312
Region 8	307, 308, 315-317
Region 9	302, 304-306, 309
Region 10	300, 301, 303, 311
Region 12	398

Dental Plan Benefits & Rates

(Rates valid 1/1/18 to 12/31/18)

	GOLD DENTAL PLAN
	100/80/50, $1,500 Annual Max, No Orthodontia
Deductible (waived for preventative)	$50 per person / $150 per family
Annual Maximum	$1,500
Preventive Care *Cleanings, exams, bitewing x-rays*	100%
Basic Services *Composite fillings, sealants, space maintainers*	80%
Major Services *Crowns, bridges, dentures, implants*	50%
Orthodontics *Lifetime maximum*	Not Covered
Endodontics & Periodontics	Covered in Major Services
Benefit Waiting Period *(Applies to Voluntary Plan or less than 10 eligible lives)*	12 Months for Major
Out of Network Reimbursement	90th Reasonable & Customary

Monthly Rates by Region	6	7	8	9	10	12
Employer Sponsored						
Employee Only	$28.94	$30.89	$33.39	$36.18	$39.21	$46.39
Employee + Spouse	$58.92	$62.89	$67.98	$73.65	$79.81	$94.41
Employee + Child(ren)	$63.02	$67.37	$72.76	$78.78	$85.37	$100.90
Employee + Spouse + Child(ren)	$99.31	$106.13	$114.65	$124.14	$134.51	$159.02
Voluntary (or groups with less than 10 eligible lives)						
Employee Only	$32.67	$34.87	$37.69	$40.84	$44.27	$52.37
Employee + Spouse	$66.52	$71.00	$76.74	$83.15	$90.10	$106.58
Employee + Child(ren)	$71.15	$76.06	$82.14	$88.94	$96.38	$113.91
Employee + Spouse + Child(ren)	$112.11	$119.81	$129.43	$140.14	$151.85	$179.52

Georgia	Zip Code
Region 6	313, 314, 318, 319
Region 7	310,312
Region 8	307, 308, 315-317
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Region 10	300, 301, 303, 311
Region 12	398

Dental Plan Benefits & Rates

(Rates valid 1/1/18 to 12/31/18)

	SILVER DENTAL PLAN
	100/80/50, $1,000 Annual Max, No Orthodontia
Deductible (waived for preventative)	$50 per person / $150 per family
Annual Maximum	$1,000
Preventive Care *Cleanings, exams, bitewing x-rays*	100%
Basic Services *Composite fillings, sealants, space maintainers*	80%
Major Services *Crowns, bridges, dentures, implants*	50%
Orthodontics *Lifetime maximum*	Not Covered
Endodontics & Periodontics	Covered in Major Services
Benefit Waiting Period *(Applies to Voluntary Plan or less than 10 eligible lives)*	12 Months for Major
Out of Network Reimbursement	90th Reasonable & Customary

Monthly Rates by Region	6	7	8	9	10	12
Employer Sponsored						
Employee Only	$26.29	$28.08	$30.35	$32.86	$35.56	$42.04
Employee + Spouse	$53.51	$57.18	$61.79	$66.89	$72.39	$85.57
Employee + Child(ren)	$58.70	$62.83	$67.82	$73.38	$79.39	$93.73
Employee + Spouse + Child(ren)	$91.94	$98.37	$106.21	$114.92	$124.34	$146.85
Voluntary (or groups with less than 10 eligible lives)						
Employee Only	$29.68	$31.70	$34.26	$37.10	$40.14	$47.46
Employee + Spouse	$60.41	$64.55	$69.76	$75.51	$81.72	$96.60
Employee + Child(ren)	$66.27	$70.93	$76.56	$82.84	$89.63	$105.81
Employee + Spouse + Child(ren)	$103.79	$111.05	$119.90	$129.74	$140.37	$165.78

Georgia	Zip Code
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Dental Allocations & Limitations

Type A—Preventative Services (deductible waived)	
Examinations	1 time in 6 months
Examinations—Problem Focused	Combined with Examinations Limit
Prophylaxis: Cleanings	1 time in 6 months
Fluoride	1 time in 12 months for a dependent child under age 14
Bitewing X-Rays	For a child under 14: 1 time in 12 months Adult: 1 time in 12 months
Labs & other tests	
Type B—Basic Services	
Sealants	1 per molar in 60 months for a child under age 16
Space Maintainers	1 per lifetime for a child under age 14
Full Mouth X-Rays	Once in 60 months
Amalgam Fillings	1 replacement per surface in 24 months
Emergency Palliative Treatment	
Periapical X-Rays	
Other X-Rays	
Resin Composite Fillings (includes coverage for composite fillings on molars)	
Oral Surgery: Simple Extractions	
General Services	
Type C—Major Service	
Consultations	2 in 12 months
Root Canal	1 tooth per lifetime
Periodontal Maintenance	1 perio. Treatments in 1 calendar yr, includes 2 cleaning (total comb: 4)
Periodontal Surgery	1 per quadrant in any 60 month period
Scaling & Root Planing	1 per quadrant in any 60 month period
Prefabricated Stainless Steel & Resin Crowns	1 per tooth in 10 calendar years
Crown Buildups / Post Core	1 per tooth in 10 calendar years
Repairs	1 in 12 months
Re-cementations	1 in 12 months
Dentures	1 in 10 calendar years
Immediate Temporary Dentures—Complete / Partial	1 replacement in 12 months
Dentures—Rebases / Relines	1 in 36 months
Denture Adjustments	1 in 12 months
Fixed Bridges	1 in 10 calendar years
Inlays / Onlays / Crowns	1 replacement per tooth in 10 calendar years
Implant Services	1 per tooth in 60 months
Implant Repairs	1 per tooth in 60 months
Implant Supported Prosthetic	1 per tooth in 10 calendar years
Tissue Conditioning	1 in 36 months
Occlusal Adjustments	1 in 12 months
General Anesthesia	
Pulpotomy	
Pulp Capping	
Pulp Therapy	
Apexificatin & Recalcification	
Periodontal Surgery—Soft & Connective Tissue Grafts	
Periodontics—Non Surgical	
Oral Surgery: Surgical Extractions	
Other Oral Surgery	

DENTAL ELIGIBILITY REQUIREMENTS

Availability of products and features are based on MetLife's guidelines, group size, underwriting, and state requirements. Like most group benefits programs, benefit programs offered by MetLife contain certain exclusions, exceptions, waiting periods, reductions, limitations, and terms for keeping them in force.

- Must be an active full time employee working at least 30 hours per week.
- Retirees, part time, temporary, seasonal, leased and independent contractors (1099) are not eligible.
- Documented proof of active, full time employment is required for all employees who are age 70 or older.
- Excluded Industries: 8021 (Offices and Clinics of Dentists) , 8072 (Dental Laboratories), 8200-8299 (School Groups), 8811 (Private Households).
- Employees on COBRA cannot exceed 15% of the enrolled lives.
- For groups with < 10 employees, no more than 75% of the group can be members of the same family (spouses, siblings, children, and parents).

PRICING ASSUMPTIONS

- Employer sponsored—employer contributes at least 50% of the employee premium.
- Voluntary—employer contributes less than 50% of the employee premium.
- Participation—minimum of 75% employer sponsored and a minimum of 35% for voluntary with a minimum of 2 enrolled lives.
- Minimum participation is the greater of 2 enrolled lives or 60% of the total eligible lives.
- Rates assume at least 75% of the eligible employees reside within the situs stat.
- An annual open enrollment is included.
- **Groups with less than 10 eligible employees will have a $15 administration fee added to their monthly bill.**

IMPORTANT NOTICE

This provides a very brief description of some of the important features of the insurance policy. It is not the insurance policy and does not represent it. Premium rates may change upon renewal. This policy is renewable at the option of the Company. This product may not be available in all states and is subject to individual state regulations.

DISCLOSURE

Dental benefits are underwritten by Metropolitan Lie Insurance Company, New York, New York. Certain claim and network administration services are provided through Vision Service Plan (VSP), Ranchero

Version L1017500097(exp1218)(All States)(DC)

Offered by:

GRIFFIN & COMPANY INSURANCE

KEYSTONE®

Underwritten by:

MetLife

Voluntary Vision Plan Benefits & Rates

***Rates are valid 1/1/18 to 12/31/18.**
***Rate guarantee period is 24 months from the group's effective date.**

	CRYSTAL VISION PLAN	
	In-Network Coverage	**Out-of-Network Reimbursement**
Eye Examination		
Comprehensive exam of visual functions and prescription of corrective eyewear.	$10 copay	$45 allowance
Retinal Imaging This screening is used to take pictures of the inside of the eye particularly the retina to look for possible changes.	Up to $39 copay	Applied to the exam allowance
Materials/Eyewear (either glasses or contacts)		
Standard Corrective Lenses		
Single Vision	$25 copay	$30 allowance
Lined bifocal	$25 copay	$50 allowance
Lined trifocal	$25 copay	$65 allowance
Lenticular	$25 copay	$100 allowance
Standard Lens Options		
Ultraviolet coating	Covered in full	Applied to the allowance
Polycarbonate (child up to age 18)	Covered in full	for the applicable corrective lenses
Additional Lens Enhancements		
Progressive Standard	Up to $55 copay	$50 allowance
Progressive Premium	Premium: Up to $95 – $105 copay	$50 allowance
Polycarbonate (adult)	Single Vision: Up to $31 copay	Applied to the allowance for the applicable corrective lens
Scratch-resistant coating (variable by type)	Up to $17 – $33 copay	
Tints (variable by type)	Single Vision: Up to $17 – $34 copay	
Anti-reflective coating (variable by type)	Up to $41 – $85 copay	
Photochromic (variable by type)	Up to $47 – $82 copay	
Frame Allowance (You will receive an additional 20% off any amount that you pay over your allowance. This offer is available from all participating locations except Costco.)	$130 allowance	$70 allowance
Costco	$70 allowance	
Contact Lenses		
Contact Fitting and Evaluation	Standard or Premium fit: Covered in full with a maximum copay of $60	Applied to the contact lens allowance
Elective lenses	$130 allowance	$105 allowance
Necessary	Covered in full after eyewear copay	$210 allowance
Frequency		
Examinations	1 per 12 months	
Standard Corrective Lenses	1 per 12 months	
Frames	1 per 24 months	
Contact Lenses	1 per 12 months	
Either glasses or contacts allowed per the frequency		
Value Added Features		
Additional Discounts on Glasses and Sunglasses	Get 20% off the cost for additional pairs of prescription glasses and non☐prescription sunglasses, including lens enhancements. At times, other promotional offers may also be available.	
Laser Vision Correction	Savings averaging 15% off the regular price or 5% off a promotional offer for laser surgery including PRK, LASIK and Custom LASIK. Offer is only available at MetLife participating locations.	
DC, GA, MD, NJ, VA		
<100 Eligible Lives	Employee Only	$8.07
	Employee + Spouse	$16.19
	Employee + Child(ren)	$13.69
	Employee + Spouse & Child(ren)	$22.59

Voluntary Vision Plan Benefits & Rates

***Rates are valid 1/1/18 to 12/31/18.**
***Rate guarantee period is 24 months from the group's effective date.**

	CLEAR VISION PLAN	
	In-Network Coverage	**Out-of-Network Reimbursement**
Eye Examination		
Comprehensive exam of visual functions and prescription of corrective eyewear.	$20 copay	$45 allowance
Retinal Imaging This screening is used to take pictures of the inside of the eye particularly the retina to look for possible changes.	Up to $39 copay	Applied to the exam allowance
Materials/Eyewear (either glasses or contacts)		
Standard Corrective Lenses **Single Vision** **Lined bifocal** **Lined trifocal** **Lenticular**	 $25 copay $25 copay $25 copay $25 copay	 $30 allowance $50 allowance $65 allowance $100 allowance
Standard Lens Options **Ultraviolet coating** **Polycarbonate (child up to age 18)**	 Covered in full Covered in full	 Applied to the allowance for the applicable corrective lenses
Additional Lens Enhancements		
Progressive Standard	Up to $55 copay	$50 allowance
Progressive Premium	Premium: Up to $95 – $105 copay	$50 allowance
Polycarbonate (adult)	Single Vision: Up to $31 copay	Applied to the allowance for the applicable corrective lens
Scratch-resistant coating (variable by type)	Up to $17 – $33 copay	
Tints (variable by type)	Single Vision: Up to $17 – $34 copay	
Anti-reflective coating (variable by type)	Up to $41 – $85 copay	
Photochromic (variable by type)	Up to $47 – $82 copay	
Frame Allowance (You will receive an additional 20% off any amount that you pay over your allowance. This offer is available from all participating locations except Costco.) **Costco**	$100 allowance $55 allowance	$55 allowance
Contact Lenses		
Contact Fitting and Evaluation	Standard or Premium fit: Covered in full with a maximum copay of $60	Applied to the contact lens allowance
Elective lenses	$100 allowance	$80 allowance
Necessary	Covered in full after eyewear copay	$210 allowance
Frequency		
Examinations **Standard Corrective Lenses** **Frames** **Contact Lenses** Either glasses or contacts allowed per the frequency	1 per 12 months 1 per 12 months 1 per 24 months 1 per 12 months	
Value Added Features		
Additional Discounts on Glasses and Sunglasses	Get 20% off the cost for additional pairs of prescription glasses and non□prescription sunglasses, including lens enhancements. At times, other promotional offers may also be available.	
Laser Vision Correction	Savings averaging 15% off the regular price or 5% off a promotional offer for laser surgery including PRK, LASIK and Custom LASIK. Offer is only available at MetLife participating locations.	
DC, GA, MD, NJ, VA		
<100 Eligible Lives	Employee Only Employee + Spouse Employee + Child(ren) Employee + Spouse & Child(ren)	$7.31 $14.64 $12.39 $20.44

VISION ELIGIBILITY REQUIREMENTS

Availability of products and features are based on MetLife's guidelines, group size, underwriting, and state requirements. Like most group benefits programs, benefit programs offered by MetLife contain certain exclusions, exceptions, waiting periods, reductions, limitations, and terms for keeping them in force.

- Must be an active full time employee working at least 30 hours per week.
- Retirees, part time, temporary, seasonal, leased and independent contractors (1099) are not eligible.
- Documented proof of active, full time employment is required for all employees who are age 70 or older.
- Excluded Industries: 8021 (Offices and Clinics of Dentists) , 8072 (Dental Laboratories), 8200-8299 (School Groups), 8811 (Private Households).
- Employees age 65 and over must be less than 20% of the group.
- For groups with < 10 employees, no more than 75% of the group can be members of the same family (spouses, siblings, children, and parents).

EXCLUSIONS

- Services and/or materials not specifically included in the Summary of Benefits as covered Plan Benefits.
- Any portion of a charge in excess of the Maximum Benefit Allowance or reimbursement indicated in the Summary of Benefits.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter).
- Two pairs of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost, stolen or damaged, except at the normal intervals when Plan Benefits are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Prescription and non-prescription medications.
- Contact lens insurance policies or service agreements.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where MetLife is required by law to pay.
- Any eye examination or any corrective eyewear required as a condition of employment.
- Services and supplies received by You or Your Dependent before the Vision Insurance starts for that person.
- Missed appointments.
- Services or materials resulting from or in the course of a Covered Person's regular occupation for pay or profit for which the Covered Person is entitled to benefits under any Workers' Compensation Law, Association's Liability Law or similar law. You must promptly claim and notify the Company of all such benefits.
- Services: (a) for which the Association of the person receiving such services is not required to pay; or (b) received at a facility maintained by the Association, labor union, mutual benefit association, or VA hospital.

EXCLUSIONS (continued)

- Services, to the extent such services, or benefits for such services, are available under a Government Plan. This exclusion will apply whether or not the person receiving the services is enrolled for the Government Plan. We will not exclude payment of benefits for such services if the Government Plan requires that Vision Insurance under the group policy be paid first. Government Plan means any plan, program, or coverage which is established under the laws or regulations of any government. The term does not include any plan, program or coverage provided by a government as an Association or Medicare.
- Services or materials received as a result of disease, defect, or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit a felony.
- Services and materials obtained while outside the United States, except for emergency vision care.
- Services, procedures, or materials for which a charge would not have been made in the absence of insurance.

PRICING ASSUMPTIONS

- Participation—minimum of 10% participation with at least 2 enrolled
- An annual open enrollment is included
- **Groups with less than 10 eligible employees will have a $15 administration fee added to their monthly bill.**

IMPORTANT NOTICE

This provides a very brief description of some of the important features of the insurance policy. It is not the insurance policy and does not represent it. Premium rates may change upon renewal. This policy is renewable at the option of the Company. This product may not be available in all states and is subject to individual state regulations.

DISCLOSURE

Vision benefits are underwritten by Metropolitan Lie Insurance Company, New York, New York. Certain claim and network administration services are provided through Vision Service Plan (VSP), Ranchero

Version L1017500097(exp1218)(All States)(DC)

Offered by:

GRIFFIN & COMPANY INSURANCE

KEYSTONE®

Underwritten by:

MetLife

Basic Life Program 2-99 Lives
(Rates valid 4/1/18 to 12/31/18)

Plan Type		$25,000/Employee	$50,000/Employee
Guarantee Issue		YES	YES
Age Reduction Schedule		35% at age 65, 50% at age 70	35% at age 65, 50% at age 70
Disability Provision		Waiver of premium—disabled prior to age 60, coverages continues to age 65	Waiver of premium—disabled prior to age 60, coverages continues to age 65
Rates per Employee/Month			
2-9 Lives	Basic Life & AD&D	$10.83	$17.65
10-24 Lives	Basic Life & AD&D	$8.70	$14.70
25-99 Lives	Basic Life & AD&D	$6.73	$13.20

BASIC AND SUPPLEMENTAL LIFE INSURANCE ELIGIBILITY REQUIREMENTS

- Must be an active full time employee working at least 30 hours per week.
- Retirees, part time, temporary, seasonal, leased and independent contractors (1099) are not eligible.
- Documented proof of active, full time employment is required for all employees who are age 70 or older.
- For groups with < 10 employees, no more than 75% of the group can be members of the same family (spouses, siblings, children, and parents).
- Excluded Industries: 8811 (Private Households)
- Pilots are not eligible for coverage.

BASIC LIFE INSURANCE PRICING ASSUMPTIONS

- Coverage must be 100% employer paid with 100% participation.
- Average age of the group must be less than 60.
- Any employee aged 75 or older is not eligible for coverage if a group is less than 25 lives.
- A completed Risk Assessment Summary is required on all cases.
- **Groups with less than 10 eligible employees will have a $15 administration fee added to their monthly bill.**

SUPPLEMENTAL LIFE STATEMENT OF HEALTH REQUIREMENTS

Statement Of Health is required in the following circumstances:

- Request coverage amounts during their initial 31-day enrollment that exceed the stated Medical Questionnaire level.
- Have been hospitalized in the last 90 days.
  * Hospitalized means admission for inpatient care in a hospital; receipt of care in a hospice facility; intermediate care facility, or long term care facility, or receipt of the following treatments wherever performed: chemotherapy, radiation therapy or dialysis.
- Have indicated a medical condition on their enrollment form.
- Apply for coverage after the period which begins on the first day on which they are eligible for coverage (or the first day following a qualifying event, if applicable) and ends at the earlier of the next following annual enrollment period or the day before the next following Policy Anniversary. In no event will this period be more than a year, or less than 31 days.
- Are Actively-at-Work but who are not currently enrolled in the plan and experience a Qualifying Event. SOH must be submitted in order to enroll for any amount of coverage.

SUPPLEMENTAL LIFE PRICING ASSUMPTIONS

- Participation - minimum 25% with at least 5 enrolled.
- Average age of the group must be less than 60.
- Any employee aged 75 or older is not eligible for coverage if a group is less than 25 lives.
- A completed Risk Assessment Summary is required on all cases.

Supplemental Life Program 10-99 Lives

(Rates valid 4/1/18 to 12/31/18)

	Supplemental Life	Dependent Supplemental Life	
	Employee	Spouse	Child
Plan Type	$10,000 Increments	$5,000 Increments	Amounts of $1,000/$2,000/ $4,000/$5,000/$10,000
Plan Maximum	Lesser of 5x pay or $500,000	50% of the employee amount up to $100,000	50% of the employee amount up to $10,000
Non-Medical Maximum Amount	10-49 Lives: $50,000 50-99 Lives: $100,000	$25,000	$10,000
Age Reduction Schedule	None	None	None
Will Prep and Estate Resolution Services	Included	Included	Included
Disability Provision	Waiver of Premium—disabled prior to age 60, coverage continues to age 65		

Employee Weekly Rates: 10-99 Lives*

AGE	Monthly Rate per $1,000	$10,000	$20,000	$30,000	$40,000	$50,000	$100,000	$150,000	$200,000	$250,000
<30	0.115	$0.27	$0.53	$0.80	$1.06	$1.33	$2.65	$3.98	$5.31	$6.63
30-34	0.142	$0.33	$0.66	$0.98	$1.31	$1.64	$3.28	$4.92	$6.55	$8.19
35-39	0.167	$0.39	$0.77	$1.16	$1.54	$1.93	$3.85	$5.78	$7.71	$9.63
40-44	0.209	$0.48	$0.96	$1.45	$1.93	$2.41	$4.82	$7.23	$9.65	$12.06
45-49	0.275	$0.63	$1.27	$1.90	$2.54	$3.17	$6.35	$9.52	$12.69	$15.87
50-54	0.484	$1.12	$2.23	$3.35	$4.47	$5.58	$11.17	$16.75	$22.34	$27.92
55-59	0.792	$1.83	$3.66	$5.48	$7.31	$9.14	$18.28	$27.42	$36.55	$45.69
60-64	1.178	$2.72	$5.44	$8.16	$10.87	$13.59	$27.18	$40.78	$54.37	$67.96
65-69	1.875	$4.33	$8.65	$12.98	$17.31	$21.63	$43.27	$64.90	$86.54	$108.17
70+	3.518	$8.12	$16.24	$24.36	$32.47	$40.59	$81.18	$121.78	$162.37	$202.96

Spouse Weekly Rates*

AGE	Monthly Rate per $1,000	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$40,000	$50,000	$100,000
<30	0.115	$0.13	$0.27	$0.40	$0.53	$0.66	$0.80	$1.06	$1.33	$2.65
30-34	0.142	$0.16	$0.33	$0.49	$0.66	$0.82	$0.98	$1.31	$1.64	$3.28
35-39	0.167	$0.19	$0.39	$0.58	$0.77	$0.96	$1.16	$1.54	$1.93	$3.85
40-44	0.209	$0.24	$0.48	$0.72	$0.96	$1.21	$1.45	$1.93	$2.41	$4.82
45-49	0.275	$0.32	$0.63	$0.95	$1.27	$1.59	$1.90	$2.54	$3.17	$6.35
50-54	0.484	$0.56	$1.12	$1.68	$2.23	$2.79	$3.35	$4.47	$5.58	$11.17
55-59	0.792	$0.91	$1.83	$2.74	$3.66	$4.57	$5.48	$7.31	$9.14	$18.28
60-64	1.178	$1.36	$2.72	$4.08	$5.44	$6.80	$8.16	$10.87	$13.59	$27.18
65-69	1.875	$2.16	$4.33	$6.49	$8.65	$10.82	$12.98	$17.31	$21.63	$43.27
70+	3.518	$4.06	$8.12	$12.18	$16.24	$20.30	$24.36	$32.47	$40.59	$81.18

Child Weekly Rates*

AGE	Monthly Rate per $1,000	$1,000	$2,000	$4,000	$5,000	$10,000
<26	0.291	$0.07	$0.13	$0.27	$0.34	$0.67

***All columns shaded in dark and light blue are Guarantee Issue.**

Offered by:

GRIFFIN & COMPANY INSURANCE

KEYSTONE®

Underwritten by:

MetLife

CONTACT

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