

Rate Exhibit for TRAVERSE CITY AREA PUBLIC SCHOOLS



Plan: POS 100/80% 500/1000 35/50/65 CAP **Quote No:** 46368
Effective Date: 01/01/2018 **Agent Name:** PRIORITY HEALTH LARGE BI
Deductible Type: Policy Year **Group No:** 775597 **Commission:** (No commission)
Rating Segment: ACTIVE FSEA - JUNE, NON AFF SUPPORT STAFF - JUNE, ACTIVE MAINTENANCE - JUNE, ADMIN/ TCAA

Product [NonGrandfathered HCR]	POS Traditional	Riders
Copay Type	Copay Aligned	DME/P&O Coins: 100%
Hospital Coinsurance		Rx Mail Order: 1.0 times
In Network	100%	
Out of Network	80%	
Deductible		
Individual - In Network	\$500	
Family - In Network	\$1,000	
Individual - Out of Network	\$1,000	
Family - Out of Network	\$2,000	
Coinsurance Max		
Individual - In Network	\$0	
Family - In Network	\$0	
Individual - Out of Network	\$1,000	
Family - Out of Network	\$2,000	

#1

Office Visit (PCP) Copay	\$35	Total Cost Sharing Out of Pocket Annual Limit Individual - In Network \$7,150 Family - In Network \$14,300 Individual - Out of Network \$14,300 Family - Out of Network \$28,600
Specialist Copay	\$50	
Urgent Care Copay	\$65	
Emergency Room Copay	\$100	
Ambulance Copay	\$100	
High Tech Imaging Copay	\$150	

Rx Deductible (Individual/Family): \$0

	Copay	Coinsurance	Max
Rx Generic	\$20	100%	\$20
Rx Preferred Brand	\$60	100%	\$60
Rx Non-preferred Brand	\$80	100%	\$80
Rx Preferred Specialty	\$60	100%	\$60
Rx Non-preferred Specialty	\$80	100%	\$80

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 677.24
 1486.40
 1822.59

	Single	Double	Family
Premium	\$570.70	\$1,255.60	\$1,675.00
Federal & State Taxes	\$10.76	\$23.67	\$31.58
Billed Rate	\$581.46	\$1,279.27	\$1,706.58
Participants	10	10	21

Sponsored Dep \$697.75

Summary	Participants	41	<u>Combined</u>
	Monthly Cost	\$53,438.00	\$54,445.48
	Annual Cost	\$641,256.00	\$653,345.76
	PEPM	\$1,303.37	\$1,327.94

This benefit plan includes federally mandated benefits for the following: \$0 copay preventive care and women's preventive care services.

Rate Exhibit for TRAVERSE CITY AREA PUBLIC SCHOOLS



Plan: POS 100/70% 250/500 deductible 10/40/80/20% **Quote No:** 46368
Effective Date: 01/01/2018 **Agent Name:** PRIORITY HEALTH LARGE BI
Deductible Type: Policy Year **Group No:** 775597 **Commission:** (No commission)
Rating Segment: ACTIVE FSEA - JUNE, NON AFF SUPPORT STAFF - JUNE, ACTIVE MAINTENANCE - JUNE, ADMIN/ TCAA

Product [NonGrandfathered HCR]	POS Traditional	Riders
Copay Type	Copay Aligned	DME/P&O Coins: 80%
Hospital Coinsurance		Rx Mail Order: 1.0 times
In Network	100%	
Out of Network	70%	
Deductible		
Individual - In Network	\$250	
Family - In Network	\$750	
Individual - Out of Network	\$500	
Family - Out of Network	\$1,000	
Coinsurance Max		
Individual - In Network	\$0	
Family - In Network	\$0	
Individual - Out of Network	\$2,500	
Family - Out of Network	\$5,000	

#2

Office Visit (PCP) Copay	\$20	
Specialist Copay	\$35	
Urgent Care Copay	\$50	
Emergency Room Copay	\$100	
Ambulance Copay	\$50	
High Tech Imaging Copay	\$150	
		Total Cost Sharing Out of Pocket Annual Limit
		Individual - In Network \$7,150
		Family - In Network \$14,300
		Individual - Out of Network \$14,300
		Family - Out of Network \$28,600

Rx Deductible (Individual/Family): \$0

	Copay	Coinsurance	Max
Rx Generic	\$10	100%	\$10
Rx Preferred Brand	\$40	100%	\$40
Rx Non-preferred Brand	\$80	100%	\$80
Rx Preferred Specialty	\$0	80%	\$100
Rx Non-preferred Specialty	\$0	80%	\$200

	Single	Double	Family
Premium	\$650.51	\$1,427.74	\$1,750.65
Federal & State Taxes	\$12.23	\$26.84	\$32.91
Billed Rate	\$662.74	\$1,454.58	\$1,783.56
Participants	21	16	15

Sponsored Dep \$795.29

Summary	Participants	52	<u>Combined</u>
	Monthly Cost	\$62,764.30	\$63,944.22
	Annual Cost	\$753,171.60	\$767,330.64
	PEPM	\$1,207.01	\$1,229.70

This benefit plan includes federally mandated benefits for the following: \$0 copay preventive care and women's preventive care services.

Rate Exhibit for TRAVERSE CITY AREA PUBLIC SCHOOLS



Plan: POS 100/80 300/600 with a 10/40/80/20% RX **Quote No:** 46368
Effective Date: 01/01/2018 **Agent Name:** PRIORITY HEALTH LARGE BI
Deductible Type: Policy Year **Group No:** 775597 **Commission:** (No commission)
Rating Segment: ACTIVE FSEA - JUNE, NON AFF SUPPORT STAFF - JUNE, ACTIVE MAINTENANCE - JUNE, ADMIN/ TCAA

Product [NonGrandfathered HCR]	POS Traditional	Riders
Copay Type	Traditional	DME/P&O Coins: 100%
Hospital Coinsurance		Rx Mail Order: 1.0 times
In Network	100%	
Out of Network	80%	
Deductible		
Individual - In Network	\$300	
Family - In Network	\$600	
Individual - Out of Network	\$600	
Family - Out of Network	\$1,200	
Coinsurance Max		
Individual - In Network	\$0	
Family - In Network	\$0	
Individual - Out of Network	\$1,000	
Family - Out of Network	\$2,000	

#3

With the exception of PCP deductible applies to all services below

Office Visit (PCP) Copay	\$20	Total Cost Sharing Out of Pocket Annual Limit	
Specialist Copay	\$20	Individual - In Network	\$7,150
Urgent Care Copay	\$20	Family - In Network	\$14,300
Emergency Room Copay	\$50	Individual - Out of Network	\$14,300
Ambulance Copay	\$0	Family - Out of Network	\$28,600

Rx Deductible (Individual/Family): \$0

	Copay	Coinsurance	Max
Rx Generic	\$10	100%	\$10
Rx Preferred Brand	\$40	100%	\$40
Rx Non-preferred Brand	\$80	100%	\$80
Rx Preferred Specialty	\$0	80%	\$100
Rx Non-preferred Specialty	\$0	80%	\$200

	Single	Double	Family
Premium	\$625.27	\$1,375.34	\$1,819.41
Federal & State Taxes	\$11.76	\$25.87	\$34.22
Billed Rate	\$637.03	\$1,401.21	\$1,853.63
Participants	5	0	1
Sponsored Dep	\$764.44		

Summary	Participants	6	<u>Combined</u>
	Monthly Cost	\$4,945.76	\$5,038.78
	Annual Cost	\$59,349.12	\$60,465.36
	PEPM	\$824.29	\$839.80

This benefit plan includes federally mandated benefits for the following: \$0 copay preventive care and women's preventive care services.