Plan: POS 100/80% 500/1000 35/50/65 CAP

Quote No: 46368

PriorityHealt

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] Copay Type	POS Traditional Copay Aligned	Riders DME/P&O Coins: 100%	
Hospital Coinsurance		Rx Mail Order: 1.0 times	
In Network	100%	To mail order. The times	
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	4	
Family - In Network	\$0	AT (
Individual - Out of Network	\$1,000		
Family - Out of Network	\$2,000		
Office Visit (PCP) Copay	\$35		
Specialist Copay	\$50	Total Cost Sharing Out of Pocket A	Annual Limit
Urgent Care Copay	\$65	Individual - In Network	\$7,150
Emergency Room Copay	\$100	Family - In Network	\$14,300
Ambulance Copay	\$100	Individual - Out of Network	\$14,300
High Tech Imaging Copay	\$150	Family - Out of Network	\$28,600

	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

677.24 1486.40

	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	Combined
	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.

PriorityHealth

Effective Date: 01/01/2018

Quote No: 46368

Deductible Type: Policy Year

Agent Name: PRIORITY HEALTH LARGE BI

Group No: 775597 Commission: (No commission)

Rating Segment: ACTIVE FSEA - JUNE, NON AFF SUPPORT STAFF - JUNE, ACTIVE MAINTENANCE - JUNE, ADMIN/ TCAA

Notes:

1. Final premium rates will vary slightly due to rounding.

2. Rates and benefits may be pending and subject to approval by the Michigan Department of Insurance and Financial Services.

3. All released quotes are based on enrollment provided by the group or agent (proposals) or extracted from the Priority Health system (renewals). Re-rating may be required if actual enrollment as of the effective date differs by 10% or more.

Other restrictions apply. Please contact your Priority Health Sales Representative for plan design approval and actual rates prior to finalizing the proposal or renewal. Priority Health is not liable for agent or employer group errors.

This Group Agreement, including the Plan Documents, Exhibit A, Exhibit B, Exhibit C (if applicable), the New Group Application, the Rate Exhibit, the Pre-Renewal letter, and any amendments or attachments/exhibits thereto, constitutes the entire agreement between Group and Health Plan. On the Effective Date, this Agreement supersedes all other agreements for health care services and benefits between the parties. However, if this Agreement, including but not limited to any Exhibit A and B, contains a typographical error which is a mistake that is known or should have been known by the parties, the parties agree that this Agreement will be amended to correct such error. If one of the parties is unwilling to amend this Agreement to correct the error, the other party may terminate this Agreement by providing written notice to the unwilling party.

Plan: POS 100/70% 250/500 deductible 10/40/80/209

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	
Сорау Туре	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			$\forall \mathcal{V}$
Individual - In Network	\$0	~	V 0
Family - In Network	\$0		
Individual - Out of Network	\$2,500		
Family - Out of Network	\$5,000		
Office Visit (PCP) Copay	\$20		
Specialist Copay	\$35	Total Cost Sharing Out of Pocket A	Annual Limit
Urgent Care Copay	\$50	Individual - In Network	\$7,150
Emergency Room Copay	\$100	Family - In Network	\$14,300
Ambulance Copay	\$50	Individual - Out of Network	\$14,300
High Tech Imaging Copay	\$150	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	Combined
	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.

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	
Сорау Туре	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	# 5	
Coinsurance Max		4.	
Individual - In Network	\$0		
Family - In Network	\$0		
Individual - Out of Network	\$1,000		
Family - Out of Network	\$2,000		
With the exception of PCP deductible ap	oplies to all services below		
Office Visit (PCP) Copay	\$20		
Specialist Copay	\$20	Total Cost Sharing Out of Pocket A	nnual Limit
Urgent Care Copay	\$20	Individual - In Network	\$7,150
Emergency Room Copay	\$50	Family - In Network	\$14,300
Ambulance Copay	\$0	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	\$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	Combined
	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.