

Rate Exhibit



Employer Group: Fennville Public Schools

Quote No: 29230

Agent Name: DONALD POBUDA

Effective Date: 07/01/2016

Commission: 3%

Rating Segment: NON-TEACHING SEGMENT

Agent/Authorized Employer Representative: _____ Date: _____

Priority Health Account Representative: _____ Date: _____

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.

Please note rates, fees, and/or claims projections do not include "Michigan claims tax", PPACA fees and assessments, or similar fees or taxes that may be imposed by the Federal Government or the State of Michigan.

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.

Rate Exhibit



Employer Group: Fennville Public Schools

Quote No: 29230

Plan: POS - Option 1

Agent Name: DONALD POBUDA

Effective Date: 07/01/2016

Commission: 3%

Rating Segment: NON-TEACHING SEGMENT

Product [NonGrandfathered HCR]	POS Traditional	Riders
Copay Type	Copay Aligned	DME/P&O Coins: 100%
Hospital Coinsurance		Rehab Visits: 20
In Network	100%	Skilled Nursing Facility 120-day annual limit, in network
Out of Network	80%	Rx Mail Order: 2.0 times
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	\$3,000	
Family - Out of Network	\$6,000	
Office Visit (PCP) Copay	\$20	
Specialist Copay	\$35	
Urgent Care Copay	\$75	
Emergency Room Copay	\$150	
Ambulance Copay	\$150	
High Tech Imaging Copay	\$150	

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	\$40	100%	\$40
Rx Non-preferred Specialty	\$80	100%	\$80

	Single	Double	Family
Premium	\$591.29	\$1,330.34	\$1,655.55
Estimated Federal & State Taxes	\$7.77	\$17.48	\$21.76
Estimated Billed Rate	\$599.06	\$1,347.82	\$1,677.31
Participants	7	2	9
Summary			Illustrative Combined
Participants		18	
Monthly Cost		\$21,699.66	\$21,984.85
Annual Cost		\$260,395.92	\$263,818.20
	PEPM	\$1,205.54	\$1,221.38

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

Rate Exhibit



Employer Group: Fennville Public Schools

Quote No: 29230

Plan: POS - Option 2

Agent Name: DONALD POBUDA

Effective Date: 07/01/2016

Commission: 3%

Rating Segment: NON-TEACHING SEGMENT

Product [NonGrandfathered HCR]	POS Traditional	Riders
Copay Type	Copay Aligned	DME/P&O Coins: 100%
Hospital Coinsurance		Rehab Visits: 20
In Network	100%	Skilled Nursing Facility 120-day annual limit, in network
Out of Network	80%	Rx Mail Order: 2.0 times
Deductible		
Individual - In Network	\$1,000	
Family - In Network	\$2,000	
Individual - Out of Network	\$2,000	
Family - Out of Network	\$4,000	
Coinsurance Max		
Individual - In Network	\$0	
Family - In Network	\$0	
Individual - Out of Network	\$3,000	
Family - Out of Network	\$6,000	
Office Visit (PCP) Copay	\$20	
Specialist Copay	\$35	
Urgent Care Copay	\$75	
Emergency Room Copay	\$150	
Ambulance Copay	\$150	
High Tech Imaging Copay	\$150	

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	\$40	100%	\$40
Rx Non-preferred Specialty	\$80	100%	\$80

	Single	Double	Family
Premium	\$562.77	\$1,266.18	\$1,575.70
Estimated Federal & State Taxes	\$7.47	\$16.81	\$20.92
Estimated Billed Rate	\$570.24	\$1,282.99	\$1,596.62
Participants	7	2	9

			Illustrative Combined
Summary	Participants	18	
	Monthly Cost	\$20,653.05	\$20,927.24
	Annual Cost	\$247,836.60	\$251,126.88
	PEPM	\$1,147.39	\$1,162.62

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

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Employer Group: Fennville Public Schools

Quote No: 29230

Plan: POS - Option 3

Agent Name: DONALD POBUDA

Effective Date: 07/01/2016

Commission: 3%

Rating Segment: NON-TEACHING SEGMENT

Product [NonGrandfathered HCR]	POS Traditional	Riders
Copay Type	Copay Aligned	DME/P&O Coins: 100%
Hospital Coinsurance		Rehab Visits: 20
In Network	100%	Skilled Nursing Facility 120-day annual limit, in network
Out of Network	80%	Rx Mail Order: 2.0 times
Deductible		
Individual - In Network	\$1,500	
Family - In Network	\$3,000	
Individual - Out of Network	\$3,000	
Family - Out of Network	\$6,000	
Coinsurance Max		
Individual - In Network	\$0	
Family - In Network	\$0	
Individual - Out of Network	\$3,000	
Family - Out of Network	\$6,000	
Office Visit (PCP) Copay	\$20	
Specialist Copay	\$35	
Urgent Care Copay	\$75	
Emergency Room Copay	\$150	
Ambulance Copay	\$150	
High Tech Imaging Copay	\$150	

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	\$40	100%	\$40
Rx Non-preferred Specialty	\$80	100%	\$80

	Single	Double	Family
Premium	\$535.96	\$1,205.86	\$1,500.63
Estimated Federal & State Taxes	\$7.20	\$16.20	\$20.16
Estimated Billed Rate	\$543.16	\$1,222.06	\$1,520.79
Participants	7	2	9

Summary	Participants	18	Illustrative <u>Combined</u>
	Monthly Cost	\$19,669.11	\$19,933.35
	Annual Cost	\$236,029.32	\$239,200.20
	PEPM	\$1,092.73	\$1,107.41

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

Rate Exhibit



Employer Group: Fennville Public Schools

Quote No: 29230

Plan: POS HSA - Option 1

Agent Name: DONALD POBUDA

Effective Date: 07/01/2016

Commission: 3%

Rating Segment: NON-TEACHING SEGMENT

Product [NonGrandfathered HCR]	POS HSA	Riders
Copay Type	Traditional	DME/P&O Coins: 100%
Hospital Coinsurance		Rehab Visits: 20
In Network	100%	Skilled Nursing Facility 45 additional days (Public School), in network
Out of Network	80%	Rx Mail Order: 2.0 times
Deductible		Rx Preventive Drug
Individual - In Network	\$1,300	
Family - In Network	\$2,600	
Individual - Out of Network	\$3,000	
Family - Out of Network	\$6,000	
Total Cost Sharing Out of Pocket Annual Limit		
Individual - In Network	\$2,000	
Family - In Network	\$4,000	
Individual - Out of Network	\$4,000	
Family - Out of Network	\$8,000	

The following services are subject to the deductible and coinsurance.

- Office Visit (PCP) Copay
- Specialist Copay
- Urgent Care Copay
- Emergency Room Copay
- Ambulance Copay
- High Tech Imaging Copay

Rx Deductible (Individual/Family): The Prescription Drugs are subject to the medical deductible prior to applicable copay.

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

	Single	Double	Family
Premium	\$498.67	\$1,121.96	\$1,396.23
Estimated Federal & State Taxes	\$6.81	\$15.32	\$19.07
Estimated Billed Rate	\$505.48	\$1,137.28	\$1,415.30
Participants	7	2	9

Summary	Participants	18	Illustrative Combined
	Monthly Cost	\$18,300.68	\$18,550.62
	Annual Cost	\$219,608.16	\$222,607.44
	PEPM	\$1,016.70	\$1,030.59

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

Rate Exhibit



Employer Group: Fennville Public Schools

Quote No: 29230

Plan: POS HSA - Option 2

Agent Name: DONALD POBUDA

Effective Date: 07/01/2016

Commission: 3%

Rating Segment: NON-TEACHING SEGMENT

Product [NonGrandfathered HCR]	POS HSA	Riders
Copay Type	Traditional	DME/P&O Coins: 100%
Hospital Coinsurance		Rehab Visits: 20
In Network	100%	Skilled Nursing Facility 45 additional days (Public School), in network
Out of Network	80%	Rx Mail Order: 2.0 times
Deductible		Rx Preventive Drug
Individual - In Network	\$2,000	
Family - In Network	\$4,000	
Individual - Out of Network	\$3,500	
Family - Out of Network	\$7,000	
Total Cost Sharing Out of Pocket Annual Limit		
Individual - In Network	\$4,000	
Family - In Network	\$8,000	
Individual - Out of Network	\$5,500	
Family - Out of Network	\$11,000	

The following services are subject to the deductible and coinsurance.

- Office Visit (PCP) Copay
- Specialist Copay
- Urgent Care Copay
- Emergency Room Copay
- Ambulance Copay
- High Tech Imaging Copay

Rx Deductible (Individual/Family): The Prescription Drugs are subject to the medical deductible prior to applicable copay.

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

	Single	Double	Family
Premium	\$449.05	\$1,010.32	\$1,257.30
Estimated Federal & State Taxes	\$6.30	\$14.17	\$17.64
Estimated Billed Rate	\$455.35	\$1,024.49	\$1,274.94
Participants	7	2	9

Summary	Participants	18	Illustrative Combined
	Monthly Cost	\$16,479.69	\$16,710.89
	Annual Cost	\$197,756.28	\$200,530.68
	PEPM	\$915.54	\$928.38

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