

**Beal City Public Schools**  
**Proposed Effective Date: July 1, 2011**  
**Market Analysis Summary**



**The following carriers provided competitive proposals which were presented to the client for consideration:**

- Blue Cross Blue Shield Community Blue 3A and Simply Blue 500
- ASR/Physician's Care Shared Funding for benefits equal to or greater than the MESSA Choices plan

**Priority Health declined to quote due to inadequate network access in the region**

**United Health Care declined to quote without claim experience**

**The following carriers are no longer competing in this market:**

- Aetna
- Humana
- Assurant

**American Community has a financial rating lower than B+ and therefore, Pinnacle does not represent this carrier**

# Blue Cross Blue Shield of Michigan Rate Quote

## Quick Quote

**Agency:** agency name  
**Agent:** Bill Longcore  
**Assoc:** None  
**Client:** Beal City Public Schools\*  
 Without teachers sn BCBSM  
 cas  
 Mount Pleasant MI 48858  
**Group SIC/Industry:** 8211 Elementary and secondary schools  
**BCBSM:** Class4

**Group/Subgroup/Suffix(Class) Specific Data**  
**Group/Suffix:** 0 0      **Effective Date:** 06/28/2011  
**BCBSM Area:** 5      **Renewal Date:** 06/28/2011  
**County:** Isabella      **Total Eligibles:** 66  
**Zip:** 48858      **Customer Size:** 21  
**Type:** Association      **Suffix/Class Size:** 21

	One		Two		Med.	
	Person	Family	Person	Family	Suppl.	Suppl.
<b>Quoted Benefits</b>						
Community Blue Plan 3A	389.93	935.83	1169.80	284.10		
Amended CB Copay Max \$1000	32.69	78.45	98.06	N/A		
HCR-PCB Preventive Care Benefits	4.96	11.90	14.88	0.85		
Mental Health Parity	6.43	15.42	19.28	N/A		
CB-OV\$20 - \$20 Office Visit/Outpatient Services Copay	-10.66	-25.59	-31.99	N/A		
CB-MT\$20 - Manipulative Treatments Copay	-8.06	-19.35	-24.18	N/A		
OCSM-12, osteopathic & chiropractic spinal manipulation w/\$20 OV	-1.60	-3.84	-4.80	N/A		
CI - Contraceptive Injections	0.00	0.00	0.00	0.00	N/A	
PCD - Prescription Contraceptive Devices	0.08	0.18	0.22	N/A		
PD-TTC\$5/\$25/\$50 RXCM	95.28	228.66	285.83	257.18		
PDCM - Prescription Contraceptive Medications	1.70	4.09	5.11	N/A		
RX90 - Retail Purchase 2X for 90-day Refill	0.00	0.00	0.00	N/A		
<b>Total Medical and Drug Rate</b>	510.73	1225.75	1532.20	542.12		
Advantage Pricing - Drug Coverage	-11.35	-27.24	-34.05	-5.83		
Advantage Pricing - Dental Coverage *	-3.78	-9.08	-11.35	-1.94		
Adjusted Medical and Drug Total	495.60	1189.44	1486.81	534.35		
Medical and Drug Enrollment	3	6	12	0		
Blue Dental Choice Plan 3	26.34	63.21	79.01	25.91		
Dental Frequency, Age and Classification Redesign	-0.84	-2.01	-2.52	-1.24		
Dental Enrollment	4	8	16	0		

# Blue Cross Blue Shield of Michigan Rate Quote

## Quick Quote

	One Person	Two Family	Med. Suppl.
Quoted Benefits Total Plan Rate	521.10	1250.64	1563.31
Monthly Premium	\$28,213.30	378 536	

Submit quote with enrollment documentation.

BCBSM has the right to adjust rates if any of the assumptions or calculations used in the quoting process are incorrect.

Cross CCF = 0.9600, Shield CCF = 0.9600, Master CCF = 0.9600

Drug CCF = 0.9600, Dental CCF = 1.0000, Vision CCF = 1.0000

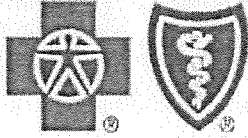
Based on census input, your group participation level is 78.0%. The group quote contains no additional participation rating factor.

BCBSM no longer markets Master Medical 65 as part of its supplemental coverage. If you choose to make any change in your medical benefit plan, and Master Medical 65 is a part of your coverage, Master Medical 65 will no longer be a part of your Medicare supplemental coverage.

To comply with new requirements in the Patient Protection and Affordable Care Act (PPACA)(also referred to as health care reform) groups may be required to make changes to their health insurance coverage. If necessary, this may result in an adjustment to the rates. To learn more about the PPACA, please visit our webpage, <http://www.bcbsm.com/healthreform/>. You should also consult with your legal counsel on how you may comply with the law and regulations and the applicability to your plan.

Final rates will be determined by BCBSM/BCN underwriting based on the actual enrollment of your group with BCBSM/BCN coverage, and will include a review of group participation.

\* This Advantage Pricing applies to contracts with BCBSM medical and dental coverage only.



## Community Blue<sup>SM</sup> PPO – Plan 3A Benefits-at-a-Glance - w/CI, PCD

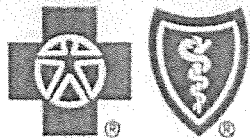
The information in this document is based on BCBSM's current interpretation of the Patient Protection and Affordable Care Act (PPACA). Interpretations of PPACA vary and the federal government continues to issue guidance on how PPACA should be interpreted and applied. Efforts will be made to update this document as more information about PPACA becomes available. This BAAG is only an educational tool and should not be relied upon as legal or compliance advice. Additionally, some PPACA requirements may differ for particular members enrolled in certain programs, and those members should consult with their plan administrators for specific details.

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits, please see the applicable BCBSM certificates and riders if your group is underwritten or your summary plan description if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

	In-network	Out-of-network *
<b>Member's responsibility (deductibles, copays and dollar maximums)</b>		
<b>Deductibles</b>	\$250 for one member, \$500 for the family (when two or more members are covered under your contract) each calendar year <b>Note:</b> Deductible may be waived if service is performed in a PPO physician's office.	\$500 for one member, \$1,000 for the family (when two or more members are covered under your contract) each calendar year <b>Note:</b> Out-of-network deductible amounts also apply toward the in-network deductible.
<b>Fixed dollar copays</b>	<ul style="list-style-type: none"> <li>\$20 copay for office visits</li> <li>\$150 copay for emergency room visit</li> </ul>	\$150 copay for emergency room visit
<b>Percent copays</b> <b>Note:</b> Copays apply once the deductible has been met.	<ul style="list-style-type: none"> <li>50% of approved amount for private duty nursing</li> <li>20% of approved amount for most other covered services (copay waived if service is performed in a PPO physician's office)</li> </ul> See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copays.	<ul style="list-style-type: none"> <li>50% of approved amount for private duty nursing</li> <li>40% of approved amount for most other covered services</li> </ul> See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copays.
<b>Annual copay dollar maximums</b> – applies to copays for all covered services – including mental health and substance abuse services – but <b>does not</b> apply to fixed dollar copays and private duty nursing percent copays <b>Note:</b> For groups with 50 or fewer employees or groups that are <b>not</b> subject to the MHP law, mental health care and substance abuse treatment copays <b>do not</b> contribute to the copay dollar maximum.	\$1,000 for one member, \$2,000 for two or more members each calendar year	\$2,000 for one member, \$4,000 for two or more members each calendar year. <b>Note:</b> Out-of-network copays also apply toward the in-network maximum.
<b>Lifetime dollar maximum</b>	None	

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

\* Services from a provider for which there is no Michigan PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.



**In-network**

**Out-of-network \***

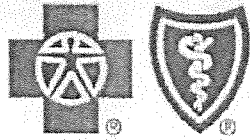
**Preventive care services**

Health maintenance exam – includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay), one per member per calendar year	Not covered
Gynecological exam	100% (no deductible or copay), one per member per calendar year	Not covered
Pap smear screening – laboratory and pathology services	100% (no deductible or copay), one per member per calendar year	Not covered
Well-baby and child care visits	100% (no deductible or copay) <ul style="list-style-type: none"> <li>• 6 visits, birth through 12 months</li> <li>• 6 visits, 13 months through 23 months</li> <li>• 6 visits, 24 months through 35 months</li> <li>• 2 visits, 36 months through 47 months</li> <li>• Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit</li> </ul>	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay)	Not covered
Fecal occult blood screening	100% (no deductible or copay), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay) <b>Note:</b> Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent copay.	60% after out-of-network deductible <b>Note:</b> Non-network readings and interpretations are payable only when the screening mammogram itself is performed by a network provider.
One per member per calendar year		
Colonoscopy – routine or medically necessary	100% for the first billed colonoscopy (no deductible or copay) <b>Note:</b> Subsequent colonoscopies performed during the same calendar year are subject to your deductible and percent copay.	60% after out-of-network deductible
One per member per calendar year		

**Physician office services**

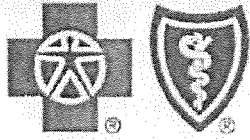
Office visits	\$20 copay per office visit	60% after out-of-network deductible, must be medically necessary
Outpatient and home medical care visits	80% after in-network deductible	60% after out-of-network deductible, must be medically necessary
Office consultations	\$20 copay per office visit	60% after out-of-network deductible, must be medically necessary
Urgent care visits	\$20 copay per office visit	60% after out-of-network deductible, must be medically necessary

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	In-network	Out-of-network *
<b>Emergency medical care</b>		
Hospital emergency room	\$150 copay per visit (copay waived if a	\$150 copay per visit (copay waived if a
Ambulance services – must be medically necessary	80% after in-network deductible	80% after In-network deductible
<b>Diagnostic services</b>		
Laboratory and pathology services	80% after in-network deductible	60% after out-of-network deductible
Diagnostic tests and x-rays	80% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	80% after in-network deductible	60% after out-of-network deductible
<b>Maternity services provided by a physician</b>		
Prenatal and postnatal care	100% (no deductible or copay) Includes covered services provided by a certified nurse midwife	60% after out-of-network deductible
Delivery and nursery care	80% after in-network deductible Includes covered services provided by a certified nurse midwife	60% after out-of-network deductible
<b>Hospital care</b>		
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies <b>Note:</b> Nonemergency services must be rendered in a participating hospital.	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible
<b>Alternatives to hospital care</b>		
Skilled nursing care – must be in a participating skilled nursing facility	80% after in-network deductible	80% after in-network deductible
	Limited to a maximum of 120 days per member per calendar year	
Hospice care	100% (no deductible or copay)	100% (no deductible or copay)
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a participating hospice program only; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	
Home health care – must be medically necessary and provided by a participating home health care agency	80% after in-network deductible	80% after in-network deductible
Home infusion therapy – must be medically necessary and given by participating home infusion therapy providers	80% after in-network deductible	80% after in-network deductible
<b>Surgical services</b>		
Surgery – includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	80% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay)	60% after out-of-network deductible
Voluntary sterilization	80% after in-network deductible	60% after out-of-network deductible

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**In-network**

**Out-of-network \***

**Human organ transplants**

Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay)	100% (no deductible or copay) – in designated facilities only
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials	80% after in-network deductible	60% after out-of-network deductible
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

**Mental health care and substance abuse treatment**

**Note:** If your employer has 51 or more employees (including seasonal and part-time) and is subject to the MHP law, covered mental health and substance abuse services are subject to the following copays. Mental health and substance abuse copays are included in the annual copay dollar maximums for all covered services. See "Annual copay dollar maximums" section for this amount. If you receive your health care benefits through a collectively bargained agreement, please contact your employer and/or union to determine when or if this benefit level applies to your plan.

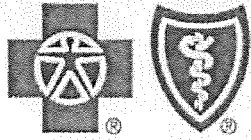
Inpatient mental health care	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Inpatient substance abuse treatment	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Outpatient mental health care • Facility and clinic	80% after in-network deductible	80% after in-network deductible, in participating facilities only
	80% after in-network deductible **	60% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities only	80% after in-network deductible **	80% after in-network deductible

\*\* Mental health and substance abuse procedures that are the equivalent of an office visit (consultative services rendered in the physician's office) will be treated and processed like an office visit, subject to the fixed dollar office visit copay.

**Note:** If your employer has 50 or fewer employees (all employees, not just eligible employees), covered mental health and substance abuse services are subject to the following copay amounts. Mental health and substance abuse copays are not limited to a copay maximum.

Inpatient mental health care	50% after in-network deductible	50% after out-of-network deductible
	Unlimited days	
Inpatient substance abuse treatment	50% after in-network deductible	50% after out-of-network deductible
	Unlimited days, up to \$15,000 annual maximum	
Outpatient mental health care • Facility and clinic	50% after in-network deductible	50% after in-network deductible, in participating facilities only
	50% (no deductible)	50% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities only	50% after in-network deductible	50% after in-network deductible
Up to the state-dollar amount that is adjusted annually		

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**In-network**

**Out-of-network \***

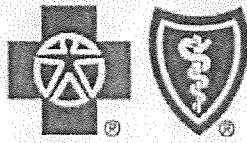
**Other covered services**

Outpatient Diabetes Management Program (ODMP)	80% after in-network deductible for diabetes medical supplies; 100% (no deductible or copay) for diabetes self-management training	60% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay)	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	\$20 copay per office visit Limited to a <b>combined</b> maximum of 12 visits per member per calendar year	60% after out-of-network deductible
Outpatient physical, speech and occupational therapy – provided for rehabilitation	80% after in-network deductible Limited to a <b>combined</b> maximum of 60 visits per member per calendar year	60% after out-of-network deductible <b>Note:</b> Services at nonparticipating outpatient physical therapy facilities are not covered.
Durable medical equipment	80% after in-network deductible	80% after in-network deductible
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible
Private duty nursing	50% after in-network deductible	50% after in-network deductible
Prescription drugs	Not covered	Not covered

**Additional Riders Selected**

Rider CI, contraceptive injections Rider PCD, prescription contraceptive devices	Adds coverage for contraceptive injections, physician-prescribed contraceptive devices such as diaphragms and IUDs, and FDA-approved oral, or self-injectable contraceptive medications as identified by BCBSM (non-self-administered drugs and devices are not covered). <b>Note:</b> These riders are only available as part of a prescription drug package. Riders CI and PCD are part of your medical-surgical coverage, subject to the same deductible and copay, if any, you pay for medical-surgical services. (Rider PCD waives the copay for services provided by a network provider.) Rider PD-CM is part of your prescription drug coverage, subject to the same copay you pay for prescription drugs.
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**Blue Preferred<sup>®</sup> Rx Prescription Drug Coverage  
with \$5 Generic / \$25 Formulary Brand / \$50 Nonformulary Brand  
Triple-Tier Copay  
Open Formulary  
Benefits-at-a-Glance - w/PD-CM**

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits, please see the applicable BCBSM certificates and riders if your group is underwritten or your summary plan description if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

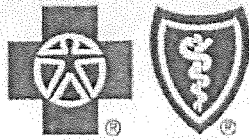
**Specialty Drugs** – The mail order pharmacy for specialty drugs is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel<sup>®</sup> and Humira<sup>®</sup>) are used to treat complex conditions such as rheumatoid arthritis. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Medco. (Medco is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at [bcbsm.com](http://bcbsm.com). Log in under *I am a Member*. If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

BCBSM reserves the right to limit the initial quantity of select specialty drugs. Your copay will be reduced by one-half for this initial fill (15 days).

		90-day retail network pharmacy	* Network mail order provider	Network pharmacy (not part of the 90-day retail network)	Non-network pharmacy
<b>Member's responsibility (copays)</b>					
<b>Tier 1 –</b> Generic or prescribed over-the-counter drugs	1 to 30-day period	\$5 copay	\$5 copay	\$5 copay	\$5 copay <i>plus</i> an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	\$10 copay	No coverage	No coverage
	84 to 90-day period	\$10 copay	\$10 copay	No coverage	No coverage
<b>Tier 2 –</b> Formulary brand-name drugs	1 to 30-day period	\$25 copay	\$25 copay	\$25 copay	\$25 copay <i>plus</i> an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	\$50 copay	No coverage	No coverage
	84 to 90-day period	\$50 copay	\$50 copay	No coverage	No coverage
<b>Tier 3 –</b> Nonformulary brand-name drugs	1 to 30-day period	\$50 copay	\$50 copay	\$50 copay	\$50 copay <i>plus</i> an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	\$100 copay	No coverage	No coverage
	84 to 90-day period	\$100 copay	\$100 copay	No coverage	No coverage

**Note:** Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law.

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**90-day retail network pharmacy**

**\* Network mail order provider**

**Network pharmacy**  
(not part of the 90-day retail network)

**Non-network pharmacy**

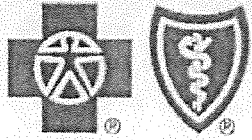
**Covered services**

	90-day retail network pharmacy	* Network mail order provider	Network pharmacy (not part of the 90-day retail network)	Non-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay	100% of approved amount less plan copay	100% of approved amount less plan copay	75% of approved amount less plan copay
Prescribed over-the-counter drugs – when covered by BCBSM	100% of approved amount less plan copay	100% of approved amount less plan copay	100% of approved amount less plan copay	75% of approved amount less plan copay
State-controlled drugs	100% of approved amount less plan copay	100% of approved amount less plan copay	100% of approved amount less plan copay	75% of approved amount less plan copay
Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs <b>Note:</b> Needles and syringes have no copay.	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	75% of approved amount less plan copay for the insulin or other covered injectable legend drug

\* Note: BCBSM will not pay for drugs obtained from non-network mail order providers, including Internet providers.

**Features of your prescription drug plan**

<b>Mandatory preauthorization</b>	A process that requires a physician to obtain approval from BCBSM <b>before</b> select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. <b>Step Therapy</b> , an initial step in the "Prior Authorization" process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at <a href="http://bcbsm.com">bcbsm.com</a> . Log in under <i>I am a Member</i> and click on <i>Prescription Drugs</i> .
<b>Mandatory maximum allowable cost (MAC) drugs</b>	If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a brand-name drug with a generic equivalent, you <b>MUST</b> pay the <b>difference</b> in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug equivalent <b>plus</b> your applicable copay regardless of whether you or your physician requests the brand name drug. <b>Exception:</b> If your physician requests and receives authorization for a brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay. <b>Note:</b> This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.
<b>Physician-administered injectable drugs</b>	Injectable drugs administered by a health care professional (not self-administered) are not covered under the pharmacy benefit, but may be covered under your medical benefit.
<b>Drug interchange and generic copay waiver</b>	Certain drugs may not be covered for future prescriptions if a suitable alternate drug is identified by BCBSM, unless the prescribing physician demonstrates that the drug is medically necessary. A list of drugs that may require authorization is available at <a href="http://bcbsm.com">bcbsm.com</a> . If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay. If your physician rewrites your prescription for the recommended brand-name alternate drug, you will have to pay a brand-name copay. In select cases BCBSM may waive the initial copay after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
<b>Quantity limits</b>	Select drugs may have limitations related to quantity and doses allowed per prescription unless the prescribing physician obtains preauthorization from BCBSM. A list of these drugs is available at <a href="http://bcbsm.com">bcbsm.com</a> .



**Additional Riders Selected**

Rider PD-CM, prescription contraceptive medications	Adds coverage for "RX only" FDA-approved oral, or self-injectable contraceptive medications as identified by BCBSM (non-self-administered drugs and devices are not covered).
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**SHARED FUNDING PROPOSAL**

**BEAL CITY PUBLIC SCHOOLS - WHOLE DISTRICT**

Effective: 7/1/2011

**PHYSICIANS CARE PROPOSAL  
PLAN 3 PPO: \$1,500 Deductible & 100% coverage thereafter  
(\$25 ER; \$10/\$20 Rx)**

Enrollment	Employee Count	Renewal Rates	Service Fee	Insurance Premium	Claims Funding	Total
Single	9	\$0.00	\$50.00	\$170.97	\$216.14	\$437.11
Double	9	\$0.00	\$50.00	\$293.71	\$374.98	\$718.69
Family	34	\$0.00	\$50.00	\$476.69	\$611.81	\$1,138.50
<b>Total Monthly</b>	<b>52</b>	<b>\$0.00</b>	<b>\$2,600.00</b>	<b>\$20,389.58</b>	<b>\$26,121.62</b>	<b>\$49,111.20</b>
<b>Total Annual</b>		<b>\$816,265.44</b>	<b>\$31,200.00</b>	<b>\$244,674.96</b>	<b>\$313,459.44</b>	<b>\$589,334.40</b>
<i>% Change from Current/Renewal</i>						<i>-27.8%</i>

**Carrier Information**

Carrier: PAN AMERICAN LIFE

Contract Type: 12/12

Covered Benefit: MED/RX

**STOP LOSS COVERAGE REQUIREMENTS AND OPTIONS:**

- 1) Stop loss quotes assume satisfaction of the carrier's minimum requirements for eligibility, participation, benefits and plan design.
- 2) Stop loss quotes above reflect an annual benefit maximum per covered person per plan year of \$5,000,000 (see ASR Health Benefits/Physicians Care Plan Highlights Benefit Description). The maximum reimbursable amount per the stop loss policy will be \$10,000,000 per covered person per policy year.
- 3) The group disclosure has been received, reviewed, and accepted.
- 4) Employers must pay premiums and fund claims based on a minimum of 15 employees for each month of the contract.
- 5) Terminal liability coverage is required on a 12/12 contract if the policy is terminated upon renewal. The client will be required to pay an additional two months of the inforce insurance premiums, claims funding factors and administrative fees based on the average enrollment from the last two months of the policy year. The additional charges will provide for coverage and payment of all eligible claims for up to 12 months beyond the policy termination date.

**GENERAL SPECIFICATIONS:**

- 6) Service fee quoted above includes the following costs: Administration fee, PPO network access fees (Physicians Care and the Multiplan Extended National network), Utilization Review services with Physicians Care Health Management, HIPAA administration and postage/handling for the direct release of checks and EOBs.
- 7) Administration services available: Dental = \$4.50 per employee per month (pepm); Vision = \$1.50 pepm; COBRA = \$1.25 pepm + ASR retains the 2% administration fee.
- 8) Initial supply of Physicians Care directories included at the point of sale. Additional Physicians Care directories are available at a cost of \$3.53 each. Directories are also available on-line at [www.physicianscare.com](http://www.physicianscare.com) and [www.multiplan.com](http://www.multiplan.com).
- 9) Physicians Care/ASR Health Benefits & Pan American Life will not be bound by any typographical errors/omissions in this proposal.
- 10) Do not cancel current coverage until confirmation of final rates and funding factors has been issued and group is accepted for coverage.
- 11) Agent receives part of the service fee as compensation.

Date of proposal: 5/17/2011



## Beal City Public Schools

Benefit Description	PPO Plan	
	In-Network	Out-Of-Network
<b>Benefit Year</b>	January 1 through December 31	
<b>Deductible per Benefit Year</b>		
Employee Pays	\$0/person \$0/family	\$5,000/person \$10,000/family
Beal City Public Schools Pays	\$1,500/person \$3,000/family	\$0/person \$0/family
The employee's deductible responsibility will be \$0 per covered person or \$0 per family for all covered services. After these amounts are paid, Beal City Public Schools will pay \$1,500 per covered person or \$3,000 per family of the deductible via a Medical Reimbursement Account (MRA).		
<b>General Benefit Percentage</b>	100% after deductible	50% after deductible
<b>Out-Of-Pocket Maximum per Benefit Year (Includes Benefit Percentage)</b>		
Employee Pays	\$1,500/person* \$3,000/family*	\$10,000/person* \$20,000/family*
*Does not include deductibles, in-network co-payments, prescription drug co-payments, or expenses that constitute a penalty for non-compliance, exceed the usual and customary charge, exceed the limits of the Plan, are subject to the Pre-Existing Conditions limitation, or are otherwise excluded.		
<b>Annual Maximum Paid per Covered Person (Includes Prescription Drugs Purchased Through the Prescription Drug Card Program or the Prescription Drug Mail Service Program)</b>	\$5,000,000 for in-network and out-of-network services combined	
<b>Outpatient Physician Services (Includes Office Visits and Second Surgical Opinions)</b>		
Physician's Fee for an Examination	\$5 co-payment per visit, then 100% (deductible waived)	50% after deductible
All Other Charges Billed in Connection with the Examination	Paid the same as any other illness; benefit percentage depends upon the type of service rendered	Paid the same as any other illness; benefit percentage depends upon the type of service rendered
<b>Immediate Care Center Visits</b>		
Physician's Fee for an Examination	\$10 co-payment per visit (waived if admitted as an inpatient or due to an accidental injury), then 100% (deductible waived)	50% after deductible
All Other Charges Billed in Connection with the Examination	Paid the same as any other illness; benefit percentage depends upon the type of service rendered	Paid the same as any other illness; benefit percentage depends upon the type of service rendered
<b>Office Surgical Procedures</b>	100% after deductible	50% after deductible
<b>Routine Preventive Care</b>		
Physician's Fee for an Examination	100%; deductible waived	Not covered
Routine X-Rays and Lab	100%; deductible waived	Not covered
Immunizations, Mammograms, and Other Routine Services	100%; deductible waived	Not covered
<b>Special Notes about Routine Preventive Care:</b>		
1. Co-insurance or an office visit co-payment may be imposed on preventive care services if either the visit is billed separately from the preventive care service or the services are provided during an office visit whose primary purpose is not preventive care (and the services are not billed separately).		
2. The Routine Preventive Care Benefit will provide coverage for certain evidence-based items (with A or B ratings) in the recommendations of the United States Preventive Services Task Force; immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; evidence-based preventive care and screenings for infants, children, and adolescents provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and additional women's preventive care and screenings in comprehensive guidelines supported by the HRSA.		
<b>Emergency Room Treatment</b>		
Physician's Fee for an Examination in the Emergency Room	\$25 co-payment per visit (waived if admitted as an inpatient or due to an accidental injury), then 100% (deductible waived)	Paid as in-network
All Other Charges Billed by the Physician in Connection with the Emergency Room Treatment	100% after deductible	Paid as in-network if treated at an in-network facility, or at 50% after deductible if treated at an out-of-network facility

Benefit Description	PPO Plan	
	In-Network	Out-Of-Network
Hospital's Fee for the Use of the Emergency Room All Other Services Billed by the Hospital in Connection with the Emergency Room Visit	100% after deductible 100% after deductible	Paid as in-network 80% after deductible
Ambulance Transportation	100% after deductible	Paid as in-network if delivered to an in-network facility, or at 100% after deductible if delivered to an out-of-network facility
<u>Prescription Drugs</u> Retail and Mail Order Prescription Drug Co-payments (90-Day Supply)	\$10/generic drug, \$20/brand-name drug	
<p><b>NOTE:</b></p> <p>1. Over-the-counter Claritin and Prilosec will be covered under the Plan the same as any other eligible generic prescription drug. A Physician's prescription for these products is required.</p> <p>2. The pharmacy will dispense generic drugs unless the prescribing Physician requests "Dispense as Written" (DAW) or a generic equivalent is not available. If the Covered Person refuses an available generic equivalent and the prescribing Physician has not requested DAW, the Covered Person must pay the applicable co-payment plus the difference in price between the brand-name drug and its generic equivalent.</p>		
Authorization Requirement Penalty for Non-Compliance: 20% of Charges from Hospital Confinement	Required for all inpatient hospital admissions and observational stays at the hospital	
<u>Inpatient Hospital Services</u> Room and Board, Surgical Services, and Ancillary Services	100% after deductible	50% after deductible
Obstetrical and Newborn Care (Includes Nurse-Midwives and Birthing Center Charges)	100% after deductible	50% after deductible
<u>Outpatient Services</u> Surgery and Surgery-Related Services Chemotherapy and Radiation Therapy Hemodialysis Diagnostic X-rays and Lab Services	100% after deductible	50% after deductible
<u>Allergy Services</u> Injections, Serum, and Testing	100% after deductible	50% after deductible
<u>Chiropractic Care</u>  38 Visits per Covered Person per Benefit Year (In-Network and Out-of-Network Services Combined)	100% after deductible	50% after deductible
<u>Rehabilitative Therapy</u> Physical Therapy, Speech Therapy, and Occupational Therapy 60 Outpatient Visits per Covered Person per Benefit Year (In-Network and Out-of-Network Services Combined)	100% after deductible	50% after deductible
Durable Medical Equipment, Prosthetics, and Orthotics	100% after deductible	50% after deductible
<u>Behavioral Care (includes Mental Health Care and Addictions Treatment)</u> Inpatient/Partial Hospitalization Services Outpatient/Intensive Outpatient Services	Paid the same as any other illness	
Infertility Treatment	Paid the same as any other illness for testing and treatment; no benefits paid for artificial means of achieving pregnancy	
Acupuncture and Acupressure	Paid the same as any other illness for services performed as preoperative anesthesia or as treatment for chronic pain; post-operative, chemotherapy-related, or pregnancy-related nausea or vomiting; post-operative dental pain (if the dental procedure was covered under the Plan); migraines; and temporomandibular disorders	
<u>Hearing Care</u>  \$1,400 Maximum Benefit Paid for a Hearing Aid per Covered Person per Ear in any 36-consecutive-Month Period; Only One Audiometric Examination, Hearing Aid Evaluation, and Conformity Test per Covered Person per Ear will be Allowed in Any 36-Consecutive-Month Period.	100%; deductible waived	100%; deductible waived
Convalescent Care and Home Health Care	100% after deductible	100% after deductible
Hospice	100% after deductible	100% after deductible



**Beal City Public Schools**

Benefit Description	Vision Plan
	Limits
<b>Benefit Percentage</b>	
Vision Examinations	100%
Eyeglass Frames	100%
Eyeglass Lenses, Including Eyeglass Lens Add-Ons Such As Tinting, Ultraviolet Coatings, Scratch-Resistant Coatings, and Anti-Reflective Coatings	100%
Contact Lenses	100%
Maximum Benefit Paid per Covered Person per Benefit Year for All Eligible Vision Services	\$250
<b>NOTE:</b> Only one pair of frames and eyeglass lenses, <u>OR</u> contact lenses up to the maximum amount allowed, will be covered by the Plan in any 24-month period.	

Benefit Description	Dental Plan
	Limits
Deductible per Benefit Year	\$0/person \$0/family
<b>Benefit Percentage</b>	
Type I - Preventive Dental Services	100%; deductible waived
Type II - Minor Restorative Dental Services	80% after deductible
Type III - Major Restorative Dental Services	80% after deductible
Type IV - Orthodontic Services (for Dependent children only)	80% after deductible
Maximum Benefit Paid per Covered Person per Benefit Year for Types I, II & III Dental Services	\$1,500
Lifetime Maximum Benefit Paid per Dependent Child for Type IV Orthodontic Services	\$2,000

Summary of Dental Procedures	
<b>Type I: Preventive Dental Services</b>	
<b>Services:</b>	<b>Special Limitations:</b>
A. Oral Examination	Limited to two times in any 12-consecutive-month period.
B. Complete Series or Panorex X-ray	Limited to one time in any 36-consecutive-month period.
C. Occlusal, Extraoral, and Individual Periapical X-Rays	No special limitations.
D. Bite-Wing X-rays	Limited to two times in any 12-consecutive-month period.
E. Bacteriologic Cultures	No special limitations.
F. Dental Prophylaxis (cleaning teeth)	Limited to two times in any 12-consecutive-month period.
G. Fluoride Treatment	Dependent children up to age 16 only. One in any 12-consecutive-month period.
H. Palliative Treatment	Paid as a separate benefit only if no other service, except x-rays, was rendered during the visit.
I. Sedative Fillings	Paid as a separate benefit only if no other service, except x-rays, was rendered during the visit.
J. Sealants	Dependent children up to age 16 only.
K. Space Maintainers	No special limitations.
L. Emergency Treatment	Exams only.
<b>Type II: Minor Restorative Dental Services</b>	
A. Periodontal Exams	Limited to one time in any three-consecutive-month period.
B. Periodontal Prophylaxis	Limited to one time in any three-consecutive-month period.
C. Diagnostic Casts	Limited to one time in any 24-consecutive-month period.
D. Stainless Steel Crowns	No special limitations.
E. Re-cement Inlays, Onlays, & Crowns	No special limitations.
F. Pulpotomy and Osseous Surgery	No special limitations.
G. Root Canal Therapy	No special limitations.
H. Apicoectomy and Retrograde Filling	No special limitations.
I. Scaling and Root Planing	Limited to two times per quadrant of the mouth in any 12-consecutive-month period.
J. Temporary Splinting	No special limitations.
K. Periodontal Appliance	Limited to one appliance in any 36-consecutive-month period.
L. Repairs to Full Dentures, Partial Dentures, Bridges	Limited to repairs or adjustments done more than 12 months after the initial insertion.
M. Relining Dentures	Limited to relining done more than 12 months after the initial insertion and then not more than one time in any 24-consecutive-month period.
N. Re-cement Bridges	No special limitations.
O. Simple Extraction	No special limitations.
P. Surgical Extraction of Impacted Teeth, Alveoplasty, Gingivectomy, & Vestibuloplasty	Not covered as a dental expense if covered under the Employer's medical plan.
Q. Root Recovery	No special limitations.
R. Incision and Drainage	No special limitations.
S. Local and General Anesthesia	No special limitations.
T. Amalgam Restorations (fillings)	Multiple restorations on one surface will be treated as a single filling.
U. Silicate, Plastic, and Composite Restorations (fillings)	No special limitations.
V. Pin Retention	Limited to two pins per tooth.
W. Gingival Curettage	No special limitations.
X. Osseous Graft or Frenectomy	No special limitations.
Y. Occlusal Adjustment	No special limitations.
Z. Bite Splint Appliances	Limited to one appliance in any five-consecutive-year period.
<b>Type III: Major Restorative Dental Services</b>	
NOTE: For replacement of items A., C., E., F., G., H., and I. below, see the subsection entitled "EXCLUSIONS AND LIMITATIONS" in the Plan document.	
A. Gold Inlays and Onlays	Covered only when the tooth cannot be restored by silver fillings.
B. Porcelain Restorations	No special limitations.
C. Crowns	Covered only if the tooth cannot be restored by a filling or by other means.
D. Post and Core	No special limitations.
E. Replacement of Teeth to Bridges and Dentures	No special limitations.
F. Full or Partial Dentures	No special limitations.
G. Fixed Bridges	No special limitations.
H. Dental Implants	No special limitations.
<b>Type IV: Orthodontic Services (Dependent Children Only)</b>	
Orthodontic Diagnostic Procedures, Surgical Therapy, and Appliance Therapy	No special limitations.