

Summary of Benefits		Blue Cross Blue Shield		Priority Health		Priority Health		Priority Health		Blue Cross Blue Shield Option		
		MESSA ABC Plan 1		PriorityHSA PPO 1350 2-tier Rx		PriorityHSA POS 1350 2-tier Rx		Priority HAS HMO 1350 2-tier Rx		BCBS Simply Blue HAS PPO 1350 Gold		
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	In-Network	Out-of-Network		
Medical		<i>Full Family deductible must be met before benefits are paid for any person on the contract</i>		<i>Full Family deductible must be met before benefits are paid for any person on the contract</i>		<i>Full Family deductible must be met before benefits are paid for any person on the contract</i>		<i>Full Family deductible must be met before benefits are paid for any person on the contract</i>		<i>Full Family deductible must be met before benefits are paid for any person on the contract</i>		
Annual Deductible		\$1,300 per individual \$2,600 per family	\$2,600 per individual \$5,200 per family	\$1,350 per individual \$2,700 per family	\$2,700 per individual \$5,400 per family	\$1,350 per individual \$2,700 per family	\$2,700 per individual \$5,400 per family	\$1,350 per individual \$2,700 per family	\$1,350 per individual \$2,700 per family	\$2,700 per individual \$5,400 per family		
Coinsurance (after Deductible is met)		0%	20%	10%	30%	10%	30%	10%	0%	20%		
Copays												
Office Visit Non Specialist		0% after deductible	20% after deductible	10% after deductible	30% after deductible	10% after deductible	30% after deductible	10% after deductible	0% after deductible	20% after deductible		
Office Visit Specialist		0% after deductible	20% after deductible	10% after deductible	30% after deductible	10% after deductible	30% after deductible	10% after deductible	0% after deductible	20% after deductible		
Emergency Room		0% after deductible	0% after deductible	10% after deductible	10% after deductible	10% after deductible	10% after deductible	10% after deductible	0% after deductible	0% after deductible		
Urgent Care		0% after deductible	20% after deductible	10% after deductible	30% after deductible	10% after deductible	30% after deductible	10% after deductible	0% after deductible	20% after deductible		
Hospital Services		Inpatient and Outpatient - 0% after deductible	Inpatient and Outpatient - 20% after deductible	Inpatient and Outpatient - 10% after deductible	Inpatient and Outpatient - 30% after deductible	Inpatient and Outpatient - 10% after deductible	Inpatient and Outpatient - 30% after deductible	Inpatient and Outpatient - 10% after deductible	Inpatient and Outpatient - 0% after deductible	Inpatient and Outpatient - 20% after deductible		
Prescription Copays		Medical deductible must be met before copays apply		Medical deductible must be met before copays apply		Medical deductible must be met before copays apply		Medical deductible must be met before copays apply		Medical deductible must be met before copays apply		
Generic/Tier 1		\$10 copay	*Copay + 20% Approved Amount	\$10 copay	Copay + 20% Approved Amount	\$10 copay	Copay + 20% Approved Amount	\$10 copay	\$10 copay	Copay + 20% Approved Amount		
Preferred Brand/Tier 2		\$20 copay		\$40 copay		\$40 copay		\$40 copay	\$40 copay		\$40 copay	
Non-Preferred Brand/Tier 3		\$40 copay		\$80 copay		\$80 copay		\$80 copay	\$80 copay		\$80 copay	\$80 copay
Specialty/Tier 4		\$40 copay		15% (max of \$150)		15% (max of \$150)		15% (max of \$150)	15% (max of \$150)		15% (max of \$150)	15% (max of \$150)
Specialty/Tier 5		\$40 copay		25% (max of \$300)		25% (max of \$300)		25% (max of \$300)	25% (max of \$300)		25% (max of \$300)	25% (max of \$300)
Pediatric Services												
Pediatric Dental		included for additional rate		included for additional rate		included for additional rate		included for additional rate		included for additional rate		
Pediatric Vision		Included		Included		Included		Included		Included		
Annual Combined Out of Pocket Max (includes Deductible, Copays & Co-Insurance)		\$2,300 per individual \$4,600 per family	\$4,600 per individual \$9,200 per family	\$2,400 per individual \$4,800 per family	\$4,800 per individual \$9,600 per family	\$2,400 per individual \$4,800 per family	\$4,800 per individual \$9,600 per family	\$2,400 per individual \$4,800 per family	\$2,350 per individual \$4,700 per family	\$4,700 per individual \$9,400 per family		
		Current Effective 7/1/2015	Renewal Effective 7/1/2016	Priority Option A Effective 7/1/2016		Priority Option B Effective 7/1/2016		Priority Option C Effective 7/1/2016		BCBSM Option 1 Effective 7/1/2016		
Coverage Type	Census (based on BCBSM April 2016 invoice)	Medical + Rx. Rates Effective 7/1/2015	Medical + Rx. Rates Effective 7/1/2016	Medical + Rx. Rate Equivalent Effective 7/1/2016		Medical + Rx. Rate Equivalent Effective 7/1/2016		Medical + Rx. Rate Equivalent Effective 7/1/2016		Medical + Rx. Rate Equivalent Effective 7/1/2016		
Employee Only	0	\$580.50	\$663.15	\$604.70		\$585.40		\$559.34		\$577.54		
Employee & One Dependent	0	\$1,304.24	\$1,490.21	\$1,358.86		\$1,315.49		\$1,256.94		\$1,297.82		
Family	7	\$1,622.69	\$1,854.11	\$1,690.69		\$1,636.72		\$1,563.87		\$1,614.74		
Total Monthly Premium	7	\$11,358.83	\$12,978.77	\$11,834.80		\$11,457.07		\$10,947.12		\$11,303.21		
% Change			14.26%	4.19%		0.86%		-3.62%		-0.49%		
Total Annual Premium	7	\$136,305.96	\$155,745.24	\$142,017.60		\$137,484.88		\$131,365.46		\$135,638.52		

Summary of Benefits		Blue Cross Blue Shield		Priority Health		Priority Health		Priority Health		Priority Health		Blue Cross Blue Shield Option				
		MESSA Choices \$500/1,000		Priority PPO 500 2-tier Rx		Priority POS 500 2-tier Rx		Priority HMO 500 2-tier Rx		Priority PPO 250 100%		Community Blue PPO Platinum \$500				
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network				
Medical																
Annual Deductible		\$500 per individual \$1,000 per family	\$1,000 per individual \$2,000 per family	\$500 per individual \$1,000 per family	\$1,000 per individual \$2,000 per family	\$500 per individual \$1,000 per family	\$1,000 per individual \$2,000 per family	\$500 per individual \$1,000 per family	\$250 per individual \$500 per family	\$500 per individual \$1,000 per family	\$500 per individual \$1,000 per family	\$1,000 per individual \$2,000 per family				
Coinsurance (after Deductible is met)		0%	20%	20%	40%	20%	40%	20%	0%	20%	10%	30%				
Copays																
Office Visit Non Specialist		\$20	20% after deductible	\$20	40% after deductible	\$20	40% after deductible	\$20	\$10	20% after deductible	\$20	30% after deductible				
Office Visit Specialist		\$20	20% after deductible	\$35	40% after deductible	\$35	40% after deductible	\$35	\$25	20% after deductible	\$20	30% after deductible				
Emergency Room		\$50	\$50	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150				
Urgent Care		\$25	20% after deductible	\$75	40% after deductible	\$75	40% after deductible	\$75	\$75	20% after deductible	\$60	30% after deductible				
Hospital Services		Inpatient and Outpatient 0% after deductible	Inpatient and Outpatient 20% after deductible	Inpatient and Outpatient 20% after deductible	Inpatient and Outpatient 40% after deductible	Inpatient and Outpatient 20% after deductible	Inpatient and Outpatient 40% after deductible	Inpatient and Outpatient 20% after deductible	Inpatient and Outpatient 0% after deductible	Inpatient and Outpatient 20% after deductible	Inpatient and Outpatient 20% after deductible	Inpatient and Outpatient 30% after deductible				
Prescription																
Copays																
Generic/Tier 1		\$10 copay	*Copay + 20% Approved Amount	\$10 copay	Copay + 20% Approved Amount	\$10 copay	Copay + 20% Approved Amount	\$10 copay	\$10 copay	Copay + 20% Approved Amount	\$5 copay	Copay + 25% Approved Amount				
Preferred Brand/Tier 2		\$20 copay		\$40 copay		\$40 copay		\$40 copay	\$40 copay		\$40 copay		\$40 copay	\$40 copay	\$40 copay	\$40 copay
Non-Preferred Brand/Tier 3		\$40 copay		\$40 copay		\$40 copay		\$40 copay	\$40 copay		\$40 copay		\$40 copay	\$40 copay	\$40 copay	\$80 copay
Specialty/Tier 4		\$40 copay		\$40 copay		\$40 copay		\$40 copay	\$40 copay		\$40 copay		\$40 copay	\$40 copay	\$40 copay	\$80 copay
Specialty/Tier 5		\$40 copay		\$40 copay		\$40 copay		\$40 copay	\$40 copay		\$40 copay		\$40 copay	\$40 copay	\$40 copay	\$80 copay
Pediatric Services																
Pediatric Dental		included for additional rate		included for additional rate		included for additional rate		included for additional rate		included for additional rate		included for additional rate				
Pediatric Vision		Included		Included		Included		Included		Included		Included				
Annual Combined Out of Pocket Max (includes Deductible, Copays & Co-Insurance)		\$2,300 per individual \$4,600 per family	\$4,600 per individual \$9,200 per family	\$5,000 per individual \$10,000 per family	\$10,000 per individual \$20,000 per family	\$5,000 per individual \$10,000 per family	\$10,000 per individual \$20,000 per family	\$5,000 per individual \$10,000 per family	\$1,400 per individual \$2,800 per family	\$2,800 per individual \$5,600 per family	\$6,600 per individual \$13,200 per family	\$13,000 per individual \$26,400 per family				
		Current	Renewal	Priority Option A		Priority Option B		Priority Option C		Priority Option G		BCBSM Option 1				
		Effective 7/1/2015	Effective 7/1/2016	Effective 7/1/2016		Effective 7/1/2016		Effective 7/1/2016		Effective 7/1/2016		Effective 7/1/2016				
Coverage Type	Census (based on BCBSM April 2016 invoice)	Medical + Rx. Rates Effective 7/1/2015		Medical + Rx. Rate Equivalent Effective 7/1/2016		Medical + Rx. Rate Equivalent Effective 7/1/2016		Medical + Rx. Rate Equivalent Effective 7/1/2016		Medical + Rx. Rate Equivalent Effective 7/1/2016		Medical + Rx. Rate Equivalent Effective 7/1/2016				
Employee Only	1	\$641.62	\$736.67	\$588.50	\$575.48	\$545.39	\$712.70	\$629.90								
Employee & One Dependent	2	\$1,441.77	\$1,655.62	\$1,322.47	\$1,293.20	\$1,225.59	\$1,601.56	\$1,415.49								
Family	11	\$1,793.83	\$2,059.96	\$1,645.40	\$1,609.00	\$1,524.87	\$1,992.65	\$1,761.14								
Total Monthly Premium	14	\$23,257.29	\$26,707.47	\$21,332.89	\$20,860.85	\$19,770.11	\$25,834.93	\$22,833.41								
% Change			14.83%	-8.27%	-10.30%	-14.99%	11.08%	-1.82%								
Total Annual Premium	14	\$279,087.48	\$320,489.64	\$255,994.68	\$250,330.24	\$237,241.34	\$310,019.12	\$274,000.92								