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School Insurance Specialists

ROYAL OAK PUBLIC SCHOOLS

RFP RESPONSE ANALYSIS

SET EMPLOYEE BENEFITS, CONSULTING SERVICES

NOVEMBER 1, 2010

SET SEG PROVIDES HIGH-QUALITY, COMPETITIVELY PRICED INSURANCE PRODUCTS TO MICHIGAN SCHOOL DISTRICTS AND EDUCATIONAL ORGANIZATIONS. WE ARE YOUR SCHOOL INSURANCE SPECIALISTS.

SET EMPLOYEE BENEFITS, EST. 1971

SEG SELF-INSURER WORKERS' COMPENSATION FUND, EST. 1977

MASB-SEG PROPERTY/CASUALTY POOL, EST. 1986

SET SEG EDUCATIONAL FOUNDATION, EST. 2005

ROYAL OAK PUBLIC SCHOOLS

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SET EMPLOYEE BENEFITS, CONSULTING SERVICES

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School Insurance Specialists

November 1, 2010

Royal Oak Public Schools
Thomas Moline, Superintendent
1123 Lexington Road
Royal Oak, MI 48073

Dear Dr. Moline:

SET has discovered extremely significant savings opportunities for your district through our RFP process!

	Product	Segment	Carrier	Savings of:
•	Medical:	Psychologist	Priority Health	**37%**
•	Dental:	Teachers	SET Self Funded	**11%**
•	Vision:	Secretaries	NVA	**47%**

Information on these and other savings options are outlined within SET's RFP response analysis which includes cost comparison summaries, carrier and product information and plan benefit designs. The list above highlights your ***best*** cost savings opportunities.

Please also note, Royal Oak Public Schools has met the requirements for PA 106 through this RFP process for the segments requested. Your district is in full compliance with the law. Please keep this proposal on file in the event you are required to submit proof of compliance.

Thank you for trusting SET Employee Benefits Consulting Services to analyze and compile your health insurance Request for Proposals. Please contact me or your Account Executive at your leisure if you have questions pertaining to your RFP Analysis.

Thank you again,

Alicia L. Perry

Alicia L. Perry, LIC
Specialist, Consulting Services

Lansing 517-482-0871 • Toll-Free 800-292-5421 • Fax 517-482-0800
115 W. Kalamazoo St. • Lansing, MI 48933-2079

Medical

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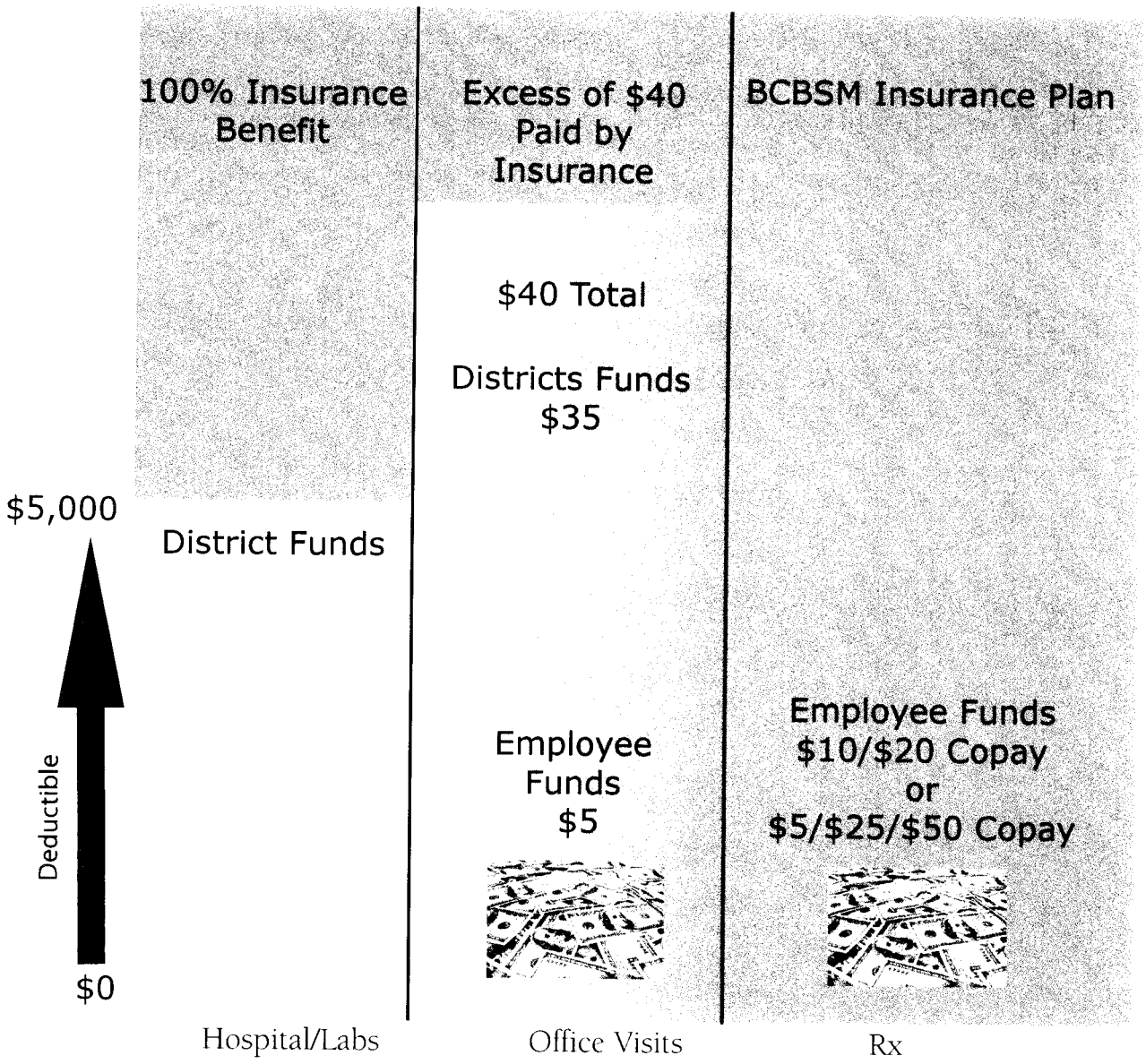
Community Blue 15, 0% Coinsurance SMRP*
$10/$20 or $5/$25/$50 Rx Copay



District sets aside 25% of the $2,500 (for a single) and $5,000 (for a two-person/family) deductible to pay medical bills and prescriptions costs. The balance of the self-funded deductible the employees do not use is retained by the district as savings.

When deductible has been met BCBSM covers 100% of hospital/labs. Office visit has $40 coinsurance; district funds $35, employee pays $5. Insured Rx has copay, which employee pays.

EHIM receives electronic claims feed from BCBSM and pays providers on behalf of the employee.

*Special Medical Reimbursement Plan

This example is illustrative of how the wrap plan works. It is not intended to represent details of coverage and is not a contract of insurance.

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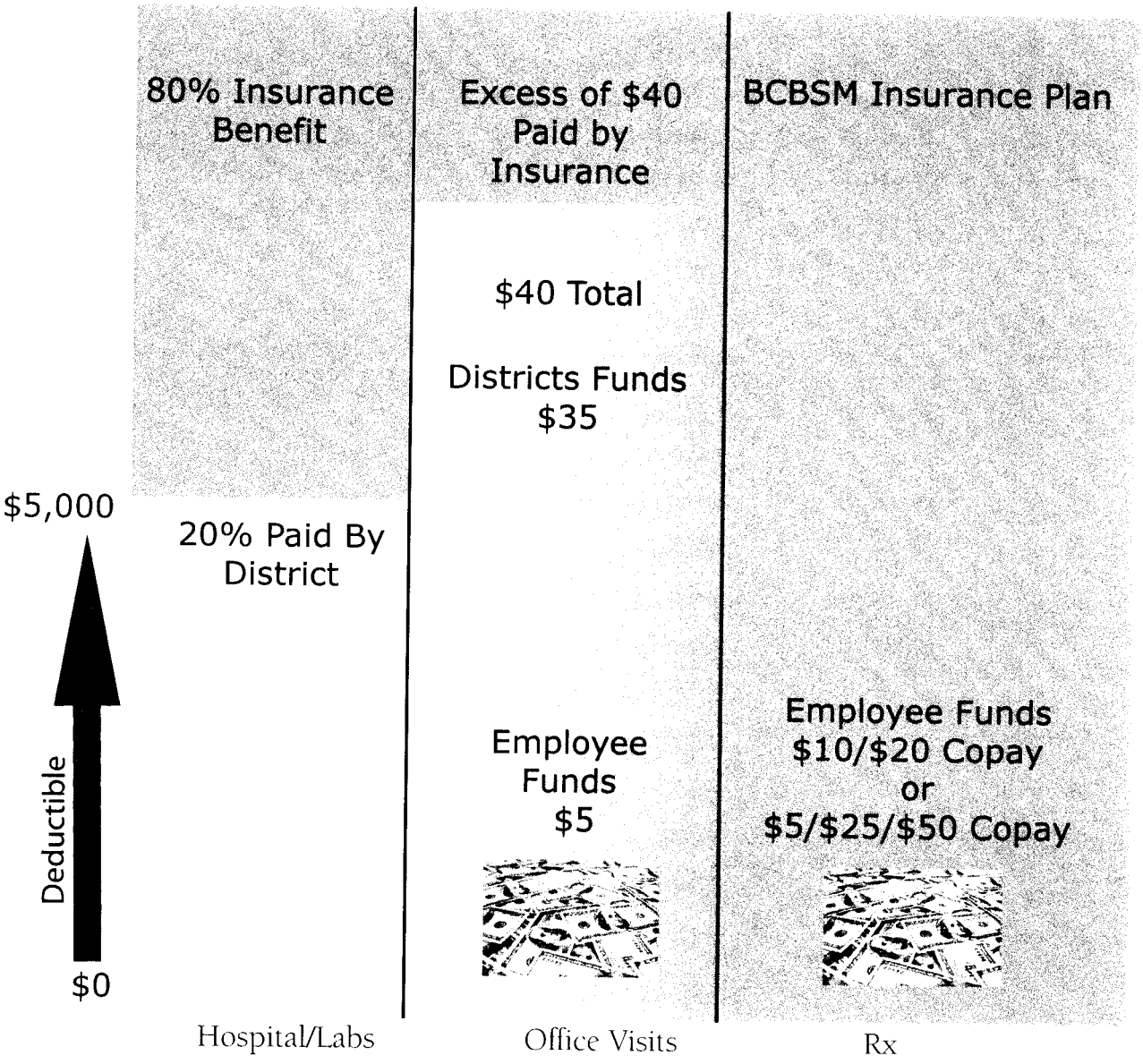
Community Blue 15, 20% Coinsurance SMRP* $10/$20 or $5/$25/$50 Rx



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DISCLAIMER: This document is a summary of certain plan features. It should not be interpreted as a complete comparison of the products represented.

Medical Plan Comparison

Royal Oak Public Schools
Teachers

	CURRENT PLAN Teachers Pak A	CURRENT PLAN Teachers Pak C	Priority Health PPO 1 $10/$20 Rx	Priority Health PPO HSA Min Plan $0/$0 Rx	Priority Health PPO HSA Combined Deductible Min Plan $0/$0 Rx	BCBSM/EHIM CB15-0 to First Dollar Insured $5/$25/$50 Rx	BCBSM/EHIM CB15-0 to School Plan II Insured $5/$25/$50 Rx
Carrier	MESSA Supercare	MESSA Choices II $10/$20	Priority Health	Priority Health	Priority Health	BCBSM/EHIM	BCBSM/EHIM
Rate Period	7/1/2010 - 6/30/2011	7/1/2010 - 6/30/2011	12/1/2010 - 11/30/2011	12/1/2010 - 11/30/2011	12/1/2010 - 11/30/2011	12/1/2010 - 6/30/2011	12/1/2010 - 6/30/2011
Quote Expiration Date	N/A	N/A	11/30/2011	11/30/2011	11/30/2011	6/30/2011	6/30/2011
Purchased Plan Features	In Network	In Network	In Network	In Network	In and Out of Network	In Network	In Network
Coinsurance	10%	0%	0%	0%	0%	0%	0%
Deductible Individual	$100	$0	$0	$1,200	$1,500	$2,500	$2,500
Deductible Family	$200	$0	$0	$2,400	$3,000	$5,000	$5,000
Post-Deductible Coinsurance - Individual	$0	$0	$0	$800	$1,500	$0	$0
Post-Deductible Coinsurance - Family	$0	$0	$0	$1,600	$3,000	$0	$0
Office Visit Copay	$0	$5	$10	$0	$0	$40	$40
Rx Copay	$10/$20	$10/$20	$10/$20 CF	$0 CF	$0 CF	$5/$25/$50	$5/$25/$50
Purchased Plan Rates - Medical	Census / Rates	Census / Rates	Census / Rates	Census / Rates	Census / Rates	Census / Rates	Census / Rates
One Person (1P)	7 / $777.73	36 / $682.32	43 / $558.18	43 / $379.53	43 / $362.80	43 / $489.08	43 / $489.08
Two Person (2P)	6 / $1,748.02	45 / $1,533.34	51 / $1,254.38	51 / $852.91	51 / $815.30	51 / $1,173.78	51 / $1,173.78
Family (FF)	10 / $1,942.08	138 / $1,703.55	148 / $1,393.61	148 / $947.58	148 / $905.80	148 / $1,467.23	148 / $1,467.23
Rx Rates/Equiv Breakout (as applicable)	Census / Rates/Equiv	Census / Rates/Equiv	Census / Rates/Equiv	Census / Rates/Equiv	Census / Rates/Equiv	Census / Rates/Equiv	Census / Rates/Equiv
One Person (1P)	7 / Included in Med	36 / Included in Med	43 / Included in Med	43 / Included in Med	43 / Included in Med	43 / Included in Med	43 / Included in Med
Two Person (2P)	6 / Included in Med	45 / Included in Med	51 / Included in Med	51 / Included in Med	51 / Included in Med	51 / Included in Med	51 / Included in Med
Family (FF)	10 / Included in Med	138 / Included in Med	148 / Included in Med	148 / Included in Med	148 / Included in Med	148 / Included in Med	148 / Included in Med
Total Annual Premium	**23 / $424,236**	**219 / $3,943,845**	**242 / $3,530,753**	**242 / $2,400,720**	**242 / $2,294,869**	**242 / $3,576,519**	**242 / $3,576,519**
Combined Annual Premium	**$4,368,081**	< TOTALS					
Deductible & Coins Funding	Deductible / Total	Deductible / Total	Ded + Coins / Total	Ded + Coins / Total	Ded + Coins / Total	Ded + Coins / Total	Ded + Coins / Total
Exposure Basis - Individual	$100 / $700	$0 / $0	$0 / $0	$1,200 / $51,600	$1,500 / $64,500	$2,500 / $107,500	$2,500 / $107,500
Exposure Basis - Family	$200 / $3,200	$0 / $0	$0 / $0	$2,400 / $477,600	$3,000 / $597,000	$5,000 / $995,000	$5,000 / $995,000
Total Exposure	$3,900	$0	$0	$529,200	$661,500	$1,102,500	$1,102,500
Estimated Utilization Rate	0%	0%	0%	100%	100%	55%	55%
Additional Ded, Coins., Rx Expense	**$0**	**$0**	**$0**	**$529,200**	**$661,500**	**$606,375**	**$606,375**
MESSA Extras Funding	Total	Total	Total	Total	Total	Total	Total
Expected Claims Per Emp Per Month	$0.00	$0.00	$0	$0	$0	$0	$25
Estimated MESSA Expense	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$72,600**
Administration	PEPM / Total	PEPM / Total	PEPM / Total	PEPM / Total	PEPM / Total	PEPM / Total	PEPM / Total
Admin Fee	$0.00	$0.00	$0.00	$0.00	$0.00	$21.00	$21.00
Combined Total Administration	**$0**	**$0**	**$0**	**$0**	**$0**	**$60,984**	**$60,984**
Resulting Plan Features	In Network	In Network	In Network	In Network	In Network	In Network	In Network
Coinsurance	10%	0%	0%	0%	0%	0%	0%
Deductible Individual	$100	$0	$0	$0	$0	$0	$0
Deductible Family	$200	$0	$0	$0	$0	$0	$0
Post-Deductible Coinsurance - Individual	$0	$0	$0	$800	$1,500	$0	$0
Post-Deductible Coinsurance - Family	$0	$0	$0	$1,600	$3,000	$0	$0
Office Visit Copay	$0	$5	$0	$0	$0	$0	$5
Rx Copay	$10/$20	$10/$20	$10/$20 CF	$0 CF	$0 CF	$5/$25/$50	$5/$25/$50
Total Costs			PEPM / Annual	PEPM / Annual	PEPM / Annual	PEPM / Annual	PEPM / Annual
Best Case Annual Cost	$4,368,081	<Totals	$3,530,753	$2,929,920	$2,956,369	$3,637,503	$3,637,503
Estimated Annual Cost	**$4,368,081**	**<Totals**	**$3,530,753**	**$2,929,920**	**$2,956,369**	**$4,243,878**	**$4,316,478**
Worst Case Annual Cost	$4,368,081	<Totals	$3,530,753	$2,929,920	$2,956,369	$4,740,003	$4,812,603
Estimated Savings - $			**$288** / **$837,328**	**$495** / **$1,438,161**	**$486** / **$1,411,712**	**$43** / **$124,203**	**$18** / **$51,603**
Estimated Savings - %			19%	33%	32%	3%	1%
Final Illustrative Plan Rates	Census / Rates	Census / Rates	Census / Rates	Census / Rates	Census / Rates	Census / Rates	Census / Rates
One Person (1P)	7 / $777.73	36 / $682.32	43 / $558.18	43 / $463.19	43 / $467.38	43 / $580.34	43 / $590.27
Two Person (2P)	6 / $1,748.02	45 / $1,533.34	51 / $1,254.38	51 / $1,040.92	51 / $1,050.31	51 / $1,392.80	51 / $1,416.63
Family (FF)	10 / $1,942.08	138 / $1,703.55	148 / $1,393.61	148 / $1,156.46	148 / $1,166.90	148 / $1,741.01	148 / $1,770.79

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Medical Rate Summary

Royal Oak Public Schools

Teachers

Assumed Effective Date: 12/1/2010

Current Plan(s) and Segment:			1P	2P	FF	Admin/ Deductible Funding	Composite	Total Cost
Teachers Pak A		**Census**	7	6	10			
	MESSA Supercare	**Rate**	$777.73	$1,748.02	$1,942.08		$1,537	$424,236
Teachers Pak C		**Census**	36	45	138			
	MESSA Choices II $10/$20	**Rate**	$682.32	$1,533.34	$1,703.55		$1,501	$3,943,845
		TOTALS:	43	51	148	**242**	$1,504	**$4,368,081**

	Equivalent Rates (Including Deductible Funding and Fees as Applicable)					Estimated	Worst Case
Product Name	**1P**	**2P**	**FF**	**Composite**	**Total Cost**	**Annual Savings**	**Exposure**
BCBSM Flexible Blue HSA Products 100% Rx (ERS Only)							
BCBSM Flexible Blue 2 (Current HSA)	$795	$1,908	$2,385	$2,002	$5,813,270	-$1,445,189	$5,813,270
BCBSM Flexible Blue 2 (Current HRA)	$784	$1,881	$2,351	$1,973	$5,730,582	-$1,362,501	$5,813,270
BCBSM FB2-0 100% Rx HSA	$795	$1,908	$2,385	$2,002	$5,813,270	-$1,445,189	$5,813,270
BCBSM Flexible Blue 3 (Current HSA)	$773	$1,856	$2,320	$1,947	$5,654,752	-$1,286,671	$5,654,752
BCBSM Flexible Blue 3 (Current HRA)	$743	$1,783	$2,229	$1,871	$5,434,252	-$1,066,171	$5,654,752
BCBSM FB3-0 100% Rx HSA	$773	$1,856	$2,320	$1,947	$5,654,752	-$1,286,671	$5,654,752
BCBSM FB4-0 100% Rx HSA	$735	$1,764	$2,205	$1,851	$5,374,699	-$1,006,618	$5,374,699
MESSA Plans	Declined						
Priority Health Conventional PPO Plans							
Priority Health PPO 1 $10/$20 Rx	$558	$1,254	$1,394	$1,216	$3,530,753	$837,328	$3,530,753
Priority Health HRA PPO Plans							
Priority Health HSA PPO Plans							
Priority Health PPO HSA Min Plan $0/$0 Rx	$463	$1,041	$1,156	$1,009	$2,929,920	$1,438,161	$2,929,920
Priority Health HSA PPO Combined Deductible Plans							
Priority Health PPO HSA Combined Deductible Min Plan $0/$0 Rx	$467	$1,050	$1,167	$1,018	$2,956,369	$1,411,712	$2,956,369
EHIM CB SMRP w BCBSM Rx							
BCBSM/EHIM CB15-0 to First Dollar Insured $10/$20 Rx	$643	$1,543	$1,860	$1,577	$4,580,558	-$212,477	$5,076,683
BCBSM/EHIM CB15-0 to First Dollar Insured $5/$25/$50 Rx	$580	$1,393	$1,741	$1,461	$4,243,878	$124,203	$4,740,003
BCBSM/EHIM CB15-0 to School Plan II Insured $10/$20 Rx	$638	$1,531	$1,845	$1,564	$4,542,908	-$174,827	$5,149,283
BCBSM/EHIM CB15-0 to School Plan II Insured $5/$25/$50 Rx	$590	$1,417	$1,771	$1,486	$4,316,478	$51,603	$4,812,603
HAP PPO Conventional Plans	No Bid Provided for this Segment						

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Medical Plan Comparison

Royal Oak Public Schools
Secretaries

DISCLAIMER: This document is a summary of certain plan features. It should not be interpreted as a complete comparison of the products represented.

	CURRENT PLAN Secretaries Pak A	CURRENT PLAN Secretaries Pak C	Priority Health PPO HSA Min Plan $0/$0 Rx	Priority Health PPO HSA Combined Deductible Min Plan $0/$0 Rx
Carrier	**MESSA Supercare**	**MESSA Choices II $10/$20**	**Priority Health**	**Priority Health**
Rate Period	7/1/2010 - 6/30/2011	7/1/2010 - 6/30/2011	12/1/2010 - 11/30/2011	12/1/2010 - 11/30/2011
Quote Expiration Date	N/A	N/A	11/30/2011	11/30/2011
Purchased Plan Features	**In Network**	**In Network**	**In Network**	**In and Out of Network**
Coinsurance	10%	0%	0%	0%
Deductible Individual	$50	$0	$1,200	$1,500
Deductible Family	$100	$0	$2,400	$3,000
Post-Deductible Coinsurance - Individual	$0	$0	$800	$1,500
Post-Deductible Coinsurance - Family	$0	$0	$1,600	$3,000
Office Visit Copay	$0	$5	$0	$0
Rx Copay	$10/$20	$10/$20	$0 CF	$0 CF
Purchased Plan Rates - Medical	**Census / Rates**	**Census / Rates**	**Census / Rates**	**Census / Rates**
One Person (1P)	0 / $786.44	7 / $682.32	7 / $461.81	7 / $441.45
Two Person (2P)	0 / $1,767.62	35 / $1,533.34	35 / $1,037.80	35 / $992.04
Family (FF)	4 / $1,963.84	14 / $1,703.55	18 / $1,153.00	18 / $1,102.16
Rx Rates/Equiv Breakout (as applicable)	**Census / Rates/Equiv**	**Census / Rates/Equiv**	**Census / Rates/Equiv**	**Census / Rates/Equiv**
One Person (1P)	0 / Included in Med	7 / Included in Med	7 / Included in Med	7 / Included in Med
Two Person (2P)	0 / Included in Med	35 / Included in Med	35 / Included in Med	35 / Included in Med
Family (FF)	4 / Included in Med	14 / Included in Med	18 / Included in Med	18 / Included in Med
Total Annual Premium	**4 / $94,264**	**56 / $987,514**	**60 / $723,716**	**60 / $691,805**
Combined Annual Premium	**$1,081,778**	**< TOTALS**		
Deductible & Coins Funding	**Deductible / Total**	**Deductible / Total**	**Ded + Coins / Total**	**Ded + Coins / Total**
Exposure Basis - Individual	$50 / $0	$0 / $0	$1,200 / $8,400	$1,500 / $10,500
Exposure Basis - Family	$100 / $400	$0 / $0	$2,400 / $127,200	$3,000 / $159,000
Total Exposure	$400	$0	$135,600	$169,500
Estimated Utilization Rate	0%	0%	100%	100%
Additional Ded, Coins., Rx Expense	**$0**	**$0**	**$135,600**	**$169,500**
MESSA Extras Funding	**Total**	**Total**	**Total**	**Total**
Expected Claims Per Emp Per Month	$0.00	$0.00	$0	$0
Estimated MESSA Expense	**$0**	**$0**	**$0**	**$0**
Administration	**PEPM / Total**	**PEPM / Total**	**PEPM / Total**	**PEPM / Total**
Admin Fee	$0.00	$0.00	$0.00	$0.00
Combined Total Administration	**$0**	**$0**	**$0**	**$0**
Resulting Plan Features	**In Network**	**In Network**	**In Network**	**In Network**
Coinsurance	10%	0%	0%	0%
Deductible Individual	$50	$0	$0	$0
Deductible Family	$100	$0	$0	$0
Post-Deductible Coinsurance - Individual	$0	$0	$800	$1,500
Post-Deductible Coinsurance - Family	$0	$0	$1,600	$3,000
Office Visit Copay	$0	$5	$0	$0
Rx Copay	$10/$20	$10/$20	$0 CF	$0 CF
Total Costs			**PEPM / Annual**	**PEPM / Annual**
Best Case Annual Cost	$1,081,778	<Totals	$859,316	$861,305
Estimated Annual Cost	**$1,081,778**	**<Totals**	**$859,316**	**$861,305**
Worst Case Annual Cost	$1,081,778	<Totals	$859,316	$861,305
Estimated Savings - $			**$309 / $222,462**	**$306 / $220,473**
Estimated Savings - %			**21%**	**20%**
Final Illustrative Plan Rates	**Census / Rates**	**Census / Rates**	**Census / Rates**	**Census / Rates**
One Person (1P)	0 / $786.44	7 / $682.32	7 / $548.34	7 / $549.61
Two Person (2P)	0 / $1,767.62	35 / $1,533.34	35 / $1,232.25	35 / $1,235.10
Family (FF)	4 / $1,963.84	14 / $1,703.55	18 / $1,369.03	18 / $1,372.20

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Medical Rate Summary

Royal Oak Public Schools

Secretaries

Assumed Effective Date: 12/1/2010

Current Plan(s) and Segment:			1P	2P	FF	Admin/ Deductible Funding	Composite	Total Cost
Secretaries Pak A		**Census**			4			
	MESSA Supercare	**Rate**	$786.44	$1,767.62	$1,963.84		$1,964	$94,264
Secretaries Pak C		**Census**	7	35	14			
	MESSA Choices II $10/$20	**Rate**	$682.32	$1,533.34	$1,703.55		$1,470	$987,514
		TOTALS:	7	35	18	**60**	$1,502	**$1,081,778**

Product Name	Equivalent Rates (Including Deductible Funding and Fees as Applicable) 1P	2P	FF	Composite	Total Cost	Estimated Annual Savings	Worst Case Exposure
BCBSM Flexible Blue HSA Products							
BCBSM FB2-0% $10/$60 Rx HSA	$765	$1,835	$2,294	$1,848	$1,330,696	-$248,918	$1,330,696
BCBSM FB3-0% $10/$60 Rx HSA	$750	$1,799	$2,249	$1,812	$1,304,556	-$222,777	$1,304,556
MESSA Plans	Declined						
Priority Health HSA PPO Plans							
Priority Health PPO HSA Min Plan $0/$0 Rx	$548	$1,232	$1,369	$1,193	$859,316	$222,462	$859,316
Priority Health HSA PPO Combined Deductible Plans							
Priority Health PPO HSA Combined Deductible Min Plan $0/$0 Rx	$550	$1,235	$1,372	$1,196	$861,305	$220,473	$861,305
EHIM FB w $10/$60 Rx SMRP							
BCBSM/EHIM FB2 to First Dollar BCBSM Rx $10/$60 to $0/$0	$790	$1,896	$2,369	$1,909	$1,374,266	-$292,488	$1,402,516
BCBSM/EHIM FB2 to First Dollar BCBSM Rx $10/$60 to $0/$20	$780	$1,873	$2,342	$1,886	$1,358,066	-$276,288	$1,386,316
BCBSM/EHIM FB3 to First Dollar BCBSM Rx $10/$60 to $0/$0	$755	$1,812	$2,265	$1,824	$1,313,576	-$231,797	$1,370,076
BCBSM/EHIM FB3 to First Dollar BCBSM Rx $10/$60 to $0/$20	$747	$1,792	$2,240	$1,804	$1,299,176	-$217,397	$1,355,676
EHIM CB SMRP w BCBSM Rx							
BCBSM/EHIM CB15-20 to First Dollar Insured $5/$25/$50 Rx	$692	$1,661	$2,077	$1,673	$1,204,465	-$122,686	$1,571,715
BCBSM/EHIM CB15-20 to School Plan II Insured $5/$25/$50 Rx	$703	$1,686	$2,108	$1,698	$1,222,465	-$140,686	$1,589,715
HAP PPO Conventional Plans	No Bid Provided for this Segment						

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Medical Plan Comparison

Royal Oak Public Schools
Psychologists

	CURRENT PLAN Psychologists		Priority Health PPO 1 $10/$20 Rx		Priority Health PPO HSA Min Plan $0/$0 Rx		Priority Health PPO HSA Combined Deductible Min Plan $0/$0 Rx		BCBSM/EHIM CB15-20 to First Dollar Insured $5/$25/$50 Rx		BCBSM/EHIM CB15-20 to School Plan II Insured $5/$25/$50 Rx	
Carrier	**MESSA Supercare**		**Priority Health**		**Priority Health**		**Priority Health**		**BCBSM/EHIM**		**BCBSM/EHIM**	
Rate Period	7/1/2010 - 6/30/2011		12/1/2010 - 11/30/2011		12/1/2010 - 11/30/2011		12/1/2010 - 11/30/2011		12/1/2010 - 6/30/2011		12/1/2010 - 6/30/2011	
Quote Expiration Date	N/A		11/30/2011		11/30/2011		11/30/2011		12/31/2010		12/31/2010	
Purchased Plan Features	**In Network**		**In Network**		**In Network**		**In and Out of Network**		**In Network**		**In Network**	
Coinsurance	10%		0%		0%		0%		20%		20%	
Deductible Individual	$100		$0		$1,200		$1,500		$2,500		$2,500	
Deductible Family	$200		$0		$2,400		$3,000		$5,000		$5,000	
Post-Deductible Coinsurance - Individual	$0		$0		$800		$1,500		$2,500		$2,500	
Post-Deductible Coinsurance - Family	$0		$0		$1,600		$3,000		$5,000		$5,000	
Office Visit Copay	$0		$10		$0		$0		$40		$40	
Rx Copay	$10/$20		$10/$20 CF		$0 CF		$0 CF		$5/$25/$50		$5/$25/$50	
Purchased Plan Rates - Medical	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**
One Person (1P)	1	$793.57	1	$605.86	1	$411.69	1	$393.53	1	$437.55	1	$437.55
Two Person (2P)	1	$1,783.66	1	$1,361.76	1	$925.32	1	$884.52	1	$1,050.09	1	$1,050.09
Family (FF)	2	$1,981.68	2	$1,513.09	2	$1,028.16	2	$982.82	2	$1,312.64	2	$1,312.64
Rx Rates/Equiv Breakout (as applicable)	**Census**	**Rates/Equiv**	**Census**	**Rates/Equiv**	**Census**	**Rates/Equiv**	**Census**	**Rates/Equiv**	**Census**	**Rates/Equiv**	**Census**	**Rates/Equiv**
One Person (1P)	1	Included in Med	1	Included in Med	1	Included in Med	1	Included in Med	1	Included in Med	1	Included in Med
Two Person (2P)	1	Included in Med	1	Included in Med	1	Included in Med	1	Included in Med	1	Included in Med	1	Included in Med
Family (FF)	2	Included in Med	2	Included in Med	2	Included in Med	2	Included in Med	2	Included in Med	2	Included in Med
Total Annual Premium	**4**	**$78,487**	**4**	**$59,926**	**4**	**$40,720**	**4**	**$38,924**	**4**	**$49,355**	**4**	**$49,355**
Deductible & Coins Funding	**Deductible**	**Total**	**Ded + Coins**	**Total**	**Ded + Coins**	**Total**	**Ded + Coins**	**Total**	**Ded + Coins**	**Total**	**Ded + Coins**	**Total**
Exposure Basis - Individual	$100	$100	$0	$0	$1,200	$1,200	$1,500	$1,500	$5,000	$5,000	$5,000	$5,000
Exposure Basis - Family	$200	$600	$0	$0	$2,400	$7,200	$3,000	$9,000	$10,000	$30,000	$10,000	$30,000
Total Exposure		$700		$0		$8,400		$10,500		$35,000		$35,000
Estimated Utilization Rate	0%		0%		100%		100%		35%		35%	
Additional Ded, Coins., Rx Expense		**$0**		**$0**		**$8,400**		**$10,500**		**$12,250**		**$12,250**
MESSA Extras Funding		**Total**		**Total**		**Total**		**Total**		**Total**		**Total**
Expected Claims Per Emp Per Month	$0.00		$0		$0		$0		$0		$25	
Estimated MESSA Expense		**$0**		**$0**		**$0**		**$0**		**$0**		**$1,200**
Administration	**PEPM**	**Total**	**PEPM**	**Total**	**PEPM**	**Total**	**PEPM**	**Total**	**PEPM**	**Total**	**PEPM**	**Total**
Admin Fee	$0.00		$0.00		$0.00		$0.00		$21.00		$21.00	
Combined Total Administration		**$0**		**$0**		**$0**		**$0**		**$1,008**		**$1,008**
Resulting Plan Features	**In Network**		**In Network**		**In Network**		**In Network**		**In Network**		**In Network**	
Coinsurance	10%		0%		0%		0%		0%		0%	
Deductible Individual	$100		$0		$0		$0		$0		$0	
Deductible Family	$200		$0		$0		$0		$0		$0	
Post-Deductible Coinsurance - Individual	$0		$0		$800		$1,500		$0		$0	
Post-Deductible Coinsurance - Family	$0		$0		$1,600		$3,000		$0		$0	
Office Visit Copay	$0		$10		$0		$0		$0		$0	
Rx Copay	$10/$20		$10/$20 CF		$0 CF		$0 CF		$5/$25/$50		$5/$25/$50	
Total Costs			**PEPM**	**Annual**	**PEPM**	**Annual**	**PEPM**	**Annual**	**PEPM**	**Annual**	**PEPM**	**Annual**
Best Case Annual Cost	$78,487			$59,926		$49,120		$49,424		$50,363		$50,363
Estimated Annual Cost	**$78,487**			**$59,926**		**$49,120**		**$49,424**		**$62,613**		**$63,813**
Worst Case Annual Cost	$78,487			$59,926		$49,120		$49,424		$85,363		$86,563
Estimated Savings - $			**$387**	**$18,561**	**$612**	**$29,367**	**$605**	**$29,063**	**$331**	**$15,874**	**$306**	**$14,674**
Estimated Savings - %				**24%**		**37%**		**37%**		**20%**		**19%**
Final Illustrative Plan Rates	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**
One Person (1P)	1	$793.57	1	$605.86	1	$496.62	1	$499.69	1	$555.09	1	$565.73
Two Person (2P)	1	$1,783.66	1	$1,361.76	1	$1,116.20	1	$1,123.12	1	$1,332.17	1	$1,357.70
Family (FF)	2	$1,981.68	2	$1,513.09	2	$1,240.26	2	$1,247.94	2	$1,665.25	2	$1,697.16

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Medical Rate Summary

Royal Oak Public Schools

Psychologists

Assumed Effective Date: 12/1/2010

Current Plan(s) and Segment:			1P	2P	FF	Admin/ Deductible Funding	Composite	Total Cost
Psychologists		**Census**	1	1	2			
	MESSA Supercare	**Rate**	$793.57	$1,783.66	$1,981.68		$1,635	$78,487
		TOTALS:	1	1	2	**4**	$1,635	**$78,487**

Product Name	Equivalent Rates (Including Deductible Funding and Fees as Applicable) 1P	2P	FF	Composite	Total Cost	Estimated Annual Savings	Worst Case Exposure
BCBSM Flexible Blue HSA Products							
BCBSM FB2-0% $10/$60 Rx HSA	$608	$1,459	$1,823	$1,428	$68,552	$9,935	$68,552
BCBSM FB3-0% $10/$60 Rx HSA	$605	$1,452	$1,815	$1,421	$68,228	$10,259	$68,228
MESSA Plans	Declined						
Priority Health Conventional PPO Plans							
Priority Health PPO 1 $10/$20 Rx	$606	$1,362	$1,513	$1,248	$59,926	$18,561	$59,926
Priority Health HSA PPO Plans							
Priority Health PPO HSA Min Plan $0/$0 Rx	$497	$1,116	$1,240	$1,023	$49,120	$29,367	$49,120
Priority Health HSA PPO Combined Deductible Plans							
Priority Health PPO HSA Combined Deductible Min Plan $0/$0 Rx	$500	$1,123	$1,248	$1,030	$49,424	$29,063	$49,424
EHIM FB w $10/$60 Rx SMRP							
BCBSM/EHIM FB2 to First Dollar BCBSM Rx $10/$60 to $0/$0	$635	$1,523	$1,904	$1,491	$71,590	$6,897	$73,340
BCBSM/EHIM FB2 to First Dollar BCBSM Rx $10/$60 to $0/$20	$625	$1,500	$1,875	$1,469	$70,510	$7,977	$72,260
BCBSM/EHIM FB3 to First Dollar BCBSM Rx $10/$60 to $0/$0	$613	$1,470	$1,838	$1,440	$69,096	$9,391	$72,596
BCBSM/EHIM FB3 to First Dollar BCBSM Rx $10/$60 to $0/$20	$604	$1,450	$1,812	$1,420	$68,136	$10,351	$71,636
EHIM CB SMRP w BCBSM Rx							
BCBSM/EHIM CB15-20 to First Dollar Insured $5/$25/$50 Rx	$555	$1,332	$1,665	$1,304	$62,613	$15,874	$85,363
BCBSM/EHIM CB15-20 to School Plan II Insured $5/$25/$50 Rx	$566	$1,358	$1,697	$1,329	$63,813	$14,674	$86,563
HAP PPO Conventional Plans	No Bid Provided for this Segment						

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DISCLAIMER: This document is a summary of certain plan features. It should not be interpreted as a complete comparison of the products represented.

Medical Plan Comparison

Royal Oak Public Schools
Administrative and Non Affiliated

CURRENT PLAN

	Administrative and Non-Affiliated		Priority Health PPO 1 $10/$20 Rx		Priority Health PPO HSA Mid Plan $0/$0 Rx		Priority Health PPO HSA Combined Deductible Min Plan $0/$0 Rx		BCBSM/EHIM CB15-20 to First Dollar Insured $5/$25/$50 Rx		BCBSM/EHIM CB15-20 to School Plan II Insured $5/$25/$50 Rx	
Carrier	BCBSM Flexible Blue 2 (Current HSA)		Priority Health		Priority Health		Priority Health		BCBSM/EHIM		BCBSM/EHIM	
Rate Period	7/1/2010 - 6/30/2011		12/1/2010 - 11/30/2011		12/1/2010 - 11/30/2011		12/1/2010 - 11/30/2011		12/1/2010 - 6/30/2011		12/1/2010 - 6/30/2011	
Quote Expiration Date	N/A		11/30/2011		11/30/2011		11/30/2011		12/31/2010		12/31/2010	
Purchased Plan Features	**In Network**		**In Network**		**In Network**		**In and Out of Network**		**In Network**		**In Network**	
Coinsurance	0%		0%		0%		0%		20%		20%	
Deductible Individual	$1,250		$0		$2,000		$1,500		$2,500		$2,500	
Deductible Family	$2,500		$0		$4,000		$3,000		$5,000		$5,000	
Post-Deductible Coinsurance - Individual	$0		$0		$2,000		$1,500		$2,500		$2,500	
Post-Deductible Coinsurance - Family	$0		$0		$4,000		$3,000		$5,000		$5,000	
Office Visit Copay	$0		$10		$0		$0		$40		$40	
Rx Copay	$0		$10/$20 CF		$0 CF		$0 CF		$5/$25/$50		$5/$25/$50	
Purchased Plan Rates - Medical	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**
One Person (1P)	4	$568.32	4	$490.11	4	$333.25	4	$318.56	4	$408.92	4	$408.92
Two Person (2P)	8	$1,363.94	8	$1,176.21	8	$799.76	8	$764.49	8	$981.40	8	$981.40
Family (FF)	12	$1,704.94	12	$1,470.30	12	$999.72	12	$955.64	12	$1,226.76	12	$1,226.76
Rx Rates/Equiv Breakout (as applicable)	**Census**	**Rates/Equiv**	**Census**	**Rates/Equiv**	**Census**	**Rates/Equiv**	**Census**	**Rates/Equiv**	**Census**	**Rates/Equiv**	**Census**	**Rates/Equiv**
One Person (1P)	4	Included in Med	4	Included in Med	4	Included in Med	4	Included in Med	4	Included in Med	4	Included in Med
Two Person (2P)	8	Included in Med	8	Included in Med	8	Included in Med	8	Included in Med	8	Included in Med	8	Included in Med
Family (FF)	12	Included in Med	12	Included in Med	12	Included in Med	12	Included in Med	12	Included in Med	12	Included in Med
Total Annual Premium	**24**	**$403,729**	**24**	**$348,165**	**24**	**$236,733**	**24**	**$226,294**	**24**	**$290,496**	**24**	**$290,496**
Deductible & Coins Funding	**Deductible**	**Total**	**Ded + Coins**	**Total**	**Ded + Coins**	**Total**	**Ded + Coins**	**Total**	**Ded + Coins**	**Total**	**Ded + Coins**	**Total**
Exposure Basis - Individual	$1,250	$5,000	$0	$0	$2,000	$8,000	$1,500	$6,000	$5,000	$20,000	$5,000	$20,000
Exposure Basis - Family	$2,500	$50,000	$0	$0	$4,000	$80,000	$3,000	$60,000	$10,000	$200,000	$10,000	$200,000
Total Exposure		$55,000		$0		$88,000		$66,000		$220,000		$220,000
Estimated Utilization Rate	100%		0%		100%		100%		35%		35%	
Additional Ded, Coins., Rx Expense		**$55,000**		**$0**		**$88,000**		**$66,000**		**$77,000**		**$77,000**
MESSA Extras Funding		**Total**		**Total**		**Total**		**Total**		**Total**		**Total**
Expected Claims Per Emp Per Month	$0.00		$0		$0		$0		$0		$25	
Estimated MESSA Expense		**$0**		**$0**		**$0**		**$0**		**$0**		**$7,200**
Administration	**PEPM**	**Total**	**PEPM**	**Total**	**PEPM**	**Total**	**PEPM**	**Total**	**PEPM**	**Total**	**PEPM**	**Total**
Admin Fee	$0.00		$0.00		$0.00		$0.00		$21.00		$21.00	
Combined Total Administration		**$0**		**$0**		**$0**		**$0**		**$6,048**		**$6,048**
Resulting Plan Features	**In Network**		**In Network**		**In Network**		**In Network**		**In Network**		**In Network**	
Coinsurance	0%		0%		0%		0%		0%		0%	
Deductible Individual	$0		$0		$0		$0		$0		$0	
Deductible Family	$0		$0		$0		$0		$0		$0	
Post-Deductible Coinsurance - Individual	$0		$0		$2,000		$1,500		$0		$0	
Post-Deductible Coinsurance - Family	$0		$0		$4,000		$3,000		$0		$0	
Office Visit Copay	$0		$10		$0		$0		$0		$5	
Rx Copay	$0		$10/$20 CF		$0 CF		$0 CF		$5/$25/$50		$5/$25/$50	
Total Costs			**PEPM**	**Annual**	**PEPM**	**Annual**	**PEPM**	**Annual**	**PEPM**	**Annual**	**PEPM**	**Annual**
Best Case Annual Cost	$458,729		$348,165		$324,733		$292,294		$296,544		$296,544	
Estimated Annual Cost	**$458,729**		**$348,165**		**$324,733**		**$292,294**		**$373,544**		**$380,744**	
Worst Case Annual Cost	$458,729		$348,165		$324,733		$292,294		$516,544		$523,744	
Estimated Savings - $			**$384**	**$110,564**	**$465**	**$133,996**	**$578**	**$166,435**	**$296**	**$85,185**	**$271**	**$77,985**
Estimated Savings - %				**24%**		**29%**		**36%**		**19%**		**17%**
Final Illustrative Plan Rates	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**
One Person (1P)	4	$645.74	4	$490.11	4	$457.13	4	$411.47	4	$525.82	4	$535.96
Two Person (2P)	8	$1,549.75	8	$1,176.21	8	$1,097.05	8	$987.46	8	$1,261.97	8	$1,286.29
Family (FF)	12	$1,937.20	12	$1,470.30	12	$1,371.34	12	$1,234.36	12	$1,577.47	12	$1,607.88

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Medical Rate Summary

Royal Oak Public Schools
Administrative and Non Affiliated

Assumed Effective Date: 12/1/2010

Current Plan(s) and Segment:		1P	2P	FF	Admin/ Deductible Funding	Composite	Total Cost
Administrative and Non-Affiliated	**Census**	4	8	12			
BCBSM Flexible Blue 2 (Current HSA)	**Rate**	$568.32	$1,363.94	$1,704.94	$55,000	$1,593	$458,729
	TOTALS:	4	8	12	**24**	$1,593	**$458,729**

Product Name	Equivalent Rates (Including Deductible Funding and Fees as Applicable) 1P	2P	FF	Composite	Total Cost	Estimated Annual Savings	Worst Case Exposure
BCBSM Flexible Blue HSA Products							
BCBSM FB2-0% $10/$60 Rx HSA	$573	$1,375	$1,719	$1,413	$406,987	$51,742	$406,987
BCBSM FB3-0% $10/$60 Rx HSA	$573	$1,376	$1,720	$1,414	$407,180	$51,549	$407,180
MESSA Plans	Declined						
Priority Health Conventional PPO Plans							
Priority Health PPO 1 $10/$20 Rx	$490	$1,176	$1,470	$1,209	$348,165	$110,564	$348,165
Priority Health HSA PPO Plans							
Priority Health PPO HSA Mid Plan $0/$0 Rx	$457	$1,097	$1,371	$1,128	$324,733	$133,996	$324,733
Priority Health HSA PPO Combined Deductible Plans							
Priority Health PPO HSA Combined Deductible Min Plan $0/$0 Rx	$411	$987	$1,234	$1,015	$292,294	$166,435	$292,294
EHIM FB w $10/$60 Rx SMRP							
BCBSM/EHIM FB2 to First Dollar BCBSM Rx $10/$60 to $0/$0	$598	$1,435	$1,794	$1,475	$424,715	$34,014	$435,715
BCBSM/EHIM FB2 to First Dollar BCBSM Rx $10/$60 to $0/$20	$589	$1,413	$1,766	$1,452	$418,235	$40,494	$429,235
BCBSM/EHIM FB3 to First Dollar BCBSM Rx $10/$60 to $0/$0	$579	$1,390	$1,737	$1,428	$411,388	$47,341	$433,388
BCBSM/EHIM FB3 to First Dollar BCBSM Rx $10/$60 to $0/$20	$571	$1,370	$1,713	$1,408	$405,628	$53,101	$427,628
EHIM CB SMRP w BCBSM Rx							
BCBSM/EHIM CB15-20 to First Dollar Insured $5/$25/$50 Rx	$526	$1,262	$1,577	$1,297	$373,544	$85,185	$516,544
BCBSM/EHIM CB15-20 to School Plan II Insured $5/$25/$50 Rx	$536	$1,286	$1,608	$1,322	$380,744	$77,985	$523,744
HAP PPO Conventional Plans	No Bid Provided for this Segment						

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DISCLAIMER: This document is a summary of certain plan features. It should not be interpreted as a complete comparison of the products represented.

Medical Plan Comparison

Royal Oak Public Schools

All Employees

	CURRENT PLAN Teachers Pak A	CURRENT PLAN Teachers Pak C	CURRENT PLAN Secretaries Pak A	CURRENT PLAN Secretaries Pak C	CURRENT PLAN Psychologists	CURRENT PLAN Administrative and Non-Affiliated
Carrier	MESSA Supercare	MESSA Choices II $10/$20	MESSA Supercare	MESSA Choices II $10/$20	MESSA Supercare	BCBSM Flexible Blue 2 (Current HSA)
Rate Period	7/1/2010 - 6/30/2011	7/1/2010 - 6/30/2011	7/1/2010 - 6/30/2011	7/1/2010 - 6/30/2011	7/1/2010 - 6/30/2011	7/1/2010 - 6/30/2011
Quote Expiration Date	N/A	N/A	N/A	N/A	N/A	N/A
Purchased Plan Features	**In Network**	**In Network**	**In Network**	**In Network**	**In Network**	**In Network**
Coinsurance	10%	0%	10%	0%	10%	0%
Deductible Individual	$100	$0	$50	$0	$100	$1,250
Deductible Family	$200	$0	$100	$0	$200	$2,500
Post-Deductible Coinsurance - Individual	$0	$0	$0	$0	$0	$0
Post-Deductible Coinsurance - Family	$0	$0	$0	$0	$0	$0
Office Visit Copay	$0	$5	$0	$5	$0	$0
Rx Copay	$10/$20	$10/$20	$10/$20	$10/$20	$10/$20	$0
Purchased Plan Rates - Medical	**Census / Rates**	**Census / Rates**	**Census / Rates**	**Census / Rates**	**Census / Rates**	**Census / Rates**
One Person (1P)	7 / $777.73	36 / $682.32	0 / $786.44	7 / $682.32	1 / $793.57	4 / $568.32
Two Person (2P)	6 / $1,748.02	45 / $1,533.34	0 / $1,767.62	35 / $1,533.34	1 / $1,783.66	8 / $1,363.94
Family (FF)	10 / $1,942.08	138 / $1,703.55	4 / $1,963.84	14 / $1,703.55	2 / $1,981.68	12 / $1,704.94
Rx Rates/Equiv Breakout (as applicable)	**Census / Rates/Equiv**	**Census / Rates/Equiv**	**Census / Rates/Equiv**	**Census / Rates/Equiv**	**Census / Rates/Equiv**	**Census / Rates/Equiv**
One Person (1P)	7 / Included in Med	36 / Included in Med	0 / Included in Med	7 / Included in Med	1 / Included in Med	4 / Included in Med
Two Person (2P)	6 / Included in Med	45 / Included in Med	0 / Included in Med	35 / Included in Med	1 / Included in Med	8 / Included in Med
Family (FF)	10 / Included in Med	138 / Included in Med	4 / Included in Med	14 / Included in Med	2 / Included in Med	12 / Included in Med
Total Annual Premium	**23 / $424,236**	**219 / $3,943,845**	**4 / $94,264**	**56 / $987,514**	**4 / $78,487**	**24 / $403,729**
Combined Annual Premium	**$5,932,075**	**< TOTALS**	**< TOTALS**	**< TOTALS**	**< TOTALS**	**< TOTALS**
Deductible & Coins Funding	**Deductible / Total**	**Deductible / Total**	**Deductible / Total**	**Deductible / Total**	**Deductible / Total**	**Deductible / Total**
Exposure Basis - Individual	$100 / $700	$0 / $0	$50 / $0	$0 / $0	$100 / $100	$1,250 / $5,000
Exposure Basis - Family	$200 / $3,200	$0 / $0	$100 / $400	$0 / $0	$200 / $600	$2,500 / $50,000
Total Exposure	$3,900	$0	$400	$0	$700	$55,000
Combined Total Exposure	**$60,000**	**< TOTALS**	**< TOTALS**	**< TOTALS**	**< TOTALS**	**< TOTALS**
Estimated Utilization Rate	0%	0%	0%	0%	0%	100%
Additional Ded, Coins., Rx Expense	**$0**	**$0**	**$0**	**$0**	**$0**	**$55,000**
Combined Ded & Coins., Rx Expense	**$55,000**	**< TOTALS**	**< TOTALS**	**< TOTALS**	**< TOTALS**	**< TOTALS**
MESSA Extras Funding	**Total**	**Total**	**Total**	**Total**	**Total**	**Total**
Expected Claims Per Emp Per Month	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Estimated MESSA Expense	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Administration	**PEPM / Total**	**PEPM / Total**	**PEPM / Total**	**PEPM / Total**	**PEPM / Total**	**PEPM / Total**
Admin Fee	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Combined Total Administration	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Resulting Plan Features	**In Network**	**In Network**	**In Network**	**In Network**	**In Network**	**In Network**
Coinsurance	10%	0%	10%	0%	10%	0%
Deductible Individual	$100	$0	$50	$0	$100	$0
Deductible Family	$200	$0	$100	$0	$200	$0
Post-Deductible Coinsurance - Individual	$0	$0	$0	$0	$0	$0
Post-Deductible Coinsurance - Family	$0	$0	$0	$0	$0	$0
Office Visit Copay	$0	$5	$0	$5	$0	$0
Rx Copay	$10/$20	$10/$20	$10/$20	$10/$20	$10/$20	$0
Total Costs						
Best Case Annual Cost	$5,987,075	<Totals	<Totals	<Totals	<Totals	<Totals
Estimated Annual Cost	**$5,987,075**	**<Totals**	**<Totals**	**<Totals**	**<Totals**	**<Totals**
Worst Case Annual Cost	$5,987,075	<Totals	<Totals	<Totals	<Totals	<Totals
Estimated Savings - $						
Estimated Savings - %						
Final Illustrative Plan Rates	**Census / Rates**	**Census / Rates**	**Census / Rates**	**Census / Rates**	**Census / Rates**	**Census / Rates**
One Person (1P)	7 / $777.73	36 / $682.32	0 / $786.44	7 / $682.32	1 / $793.57	4 / $645.74
Two Person (2P)	6 / $1,748.02	45 / $1,533.34	0 / $1,767.62	35 / $1,533.34	1 / $1,783.66	8 / $1,549.75
Family (FF)	10 / $1,942.08	138 / $1,703.55	4 / $1,963.84	14 / $1,703.55	2 / $1,981.68	12 / $1,937.20

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DISCLAIMER: This document is a summary of certain plan features. It should not be interpreted as a complete

Medical Plan Comparison

Royal Oak Public Schools
All Employees

	Priority Health PPO 1 $10/$20 Rx	Priority Health PPO HSA Min Plan $0/$0 Rx	Priority Health PPO HSA Combined Deductible Min Plan $0/$0 Rx	BCBSM/EHIM CB15-0 to First Dollar Insured $5/$25/$50 Rx	BCBSM/EHIM CB15-0 to School Plan II Insured $5/$25/$50 Rx
Carrier	Priority Health	Priority Health	Priority Health	BCBSM/EHIM	BCBSM/EHIM
Rate Period	12/1/2010 - 11/30/2011	12/1/2010 - 11/30/2011	12/1/2010 - 11/30/2011	12/1/2010 - 6/30/2011	12/1/2010 - 6/30/2011
Quote Expiration Date	11/30/2011	11/30/2011	11/30/2011	6/30/2011	6/30/2011
Purchased Plan Features	In Network	In Network	In and Out of Network	In Network	In Network
Coinsurance	0%	0%	0%	0%	0%
Deductible Individual	$0	$1,200	$1,500	$2,500	$2,500
Deductible Family	$0	$2,400	$3,000	$5,000	$5,000
Post-Deductible Coinsurance - Individual	$0	$800	$1,500	$0	$0
Post-Deductible Coinsurance - Family	$0	$1,600	$3,000	$0	$0
Office Visit Copay	$10	$0	$0	$40	$40
Rx Copay	$10/$20 CF	$0 CF	$0 CF	$5/$25/$50	$5/$25/$50
Purchased Plan Rates - Medical					
One Person (1P)	Census: 55 — Rates: $577.46	Census: 55 — Rates: $392.64	Census: 55 — Rates: $375.33	Census: 55 — Rates: $489.08	Census: 55 — Rates: $489.08
Two Person (2P)	Census: 95 — Rates: $1,297.73	Census: 95 — Rates: $882.38	Census: 95 — Rates: $843.48	Census: 95 — Rates: $1,173.78	Census: 95 — Rates: $1,173.78
Family (FF)	Census: 180 — Rates: $1,441.78	Census: 180 — Rates: $980.33	Census: 180 — Rates: $937.11	Census: 180 — Rates: $1,467.23	Census: 180 — Rates: $1,467.23
Rx Rates/Equiv Breakout (as applicable)					
One Person (1P)	Census: 55 — Rates/Equiv: Included in Med	Census: 55 — Rates/Equiv: Included in Med	Census: 55 — Rates/Equiv: Included in Med	Census: 55 — Rates/Equiv: Included in Med	Census: 55 — Rates/Equiv: Included in Med
Two Person (2P)	Census: 95 — Rates/Equiv: Included in Med	Census: 95 — Rates/Equiv: Included in Med	Census: 95 — Rates/Equiv: Included in Med	Census: 95 — Rates/Equiv: Included in Med	Census: 95 — Rates/Equiv: Included in Med
Family (FF)	Census: 180 — Rates/Equiv: Included in Med	Census: 180 — Rates/Equiv: Included in Med	Census: 180 — Rates/Equiv: Included in Med	Census: 180 — Rates/Equiv: Included in Med	Census: 180 — Rates/Equiv: Included in Med
Total Annual Premium	**330 — $4,974,781**	**330 — $3,382,568**	**330 — $3,233,443**	**330 — $4,830,119**	**330 — $4,830,119**
Combined Annual Premium					
Deductible & Coins Funding	Ded + Coins: $0 — Total: $0	Ded + Coins: $1,200 — Total: $66,000	Ded + Coins: $1,500 — Total: $82,500	Ded + Coins: $2,500 — Total: $137,500	Ded + Coins: $2,500 — Total: $137,500
Exposure Basis - Individual	$0	$2,400 — $660,000	$3,000 — $825,000	$5,000 — $1,375,000	$5,000 — $1,375,000
Exposure Basis - Family	$0	$726,000	$907,500	$1,512,500	$1,512,500
Total Exposure	$0				
Combined Total Exposure		100% — **$726,000**	100% — **$907,500**	55% — **$831,875**	55% — **$831,875**
Estimated Utilization Rate	0%				
Additional Ded, Coins., Rx Expense	**$0**				
Combined Ded & Coins., Rx Expense		**Total**	**Total**	**Total**	**Total**
MESSA Extras Funding		$0 — **$0**	$0 — **$0**	$0 — **$0**	$25 — **$99,000**
Expected Claims Per Emp Per Month	**Total**				
Estimated MESSA Expense	$0	**PEPM: Total**	**PEPM: Total**	**PEPM: Total**	**PEPM: Total**
Administration		$0.00 — **$0**	$0.00 — **$0**	$21.00 — **$83,160**	$21.00 — **$83,160**
Admin Fee	**PEPM: Total**				
Combined Total Administration	$0.00 — **$0**	**In Network**	**In Network**	**In Network**	**In Network**
Resulting Plan Features	**In Network**	0%	0%	0%	0%
Coinsurance	0%	$0	$0	$0	$0
Deductible Individual	$0	$0	$0	$0	$0
Deductible Family	$0	$800	$1,500	$0	$0
Post-Deductible Coinsurance - Individual	$0	$1,600	$3,000	$0	$0
Post-Deductible Coinsurance - Family	$0	$0	$0	$0	$0
Office Visit Copay	$10	$0 CF	$0 CF	$5/$25/$50	$5/$25/$50
Rx Copay	$10/$20 CF				
Total Costs	**PEPM: Annual**	**PEPM: Annual**	**PEPM: Annual**	**PEPM: Annual**	**PEPM: Annual**
Best Case Annual Cost	$4,974,781	$4,108,568	$4,140,943	$4,913,279	$4,913,279
Estimated Annual Cost	**$4,974,781**	**$4,108,568**	**$4,140,943**	**$5,745,154**	**$5,844,154**
Worst Case Annual Cost	$4,974,781	$4,108,568	$4,140,943	$6,425,779	$6,524,779
Estimated Savings - $	**$256 — $1,012,295**	**$474 — $1,878,507**	**$466 — $1,846,133**	**$61 — $241,922**	**$36 — $142,922**
Estimated Savings - %	**17%**	**31%**	**31%**	**4%**	**2%**
Final Illustrative Plan Rates	**Census: Rates**	**Census: Rates**	**Census: Rates**	**Census: Rates**	**Census: Rates**
One Person (1P)	55 — $577.46	55 — $476.91	55 — $480.67	55 — $581.73	55 — $591.76
Two Person (2P)	95 — $1,297.73	95 — $1,071.77	95 — $1,080.21	95 — $1,396.15	95 — $1,420.20
Family (FF)	180 — $1,441.78	180 — $1,190.74	180 — $1,200.12	180 — $1,745.19	180 — $1,775.26

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Medical Rate Summary

Royal Oak Public Schools

All Employees

Assumed Effective Date: 12/1/2010

Current Plan(s) and Segment:			1P	2P	FF	Admin/ Deductible Funding	Composite	Total Cost
Teachers Pak A		**Census**	7	6	10			
	MESSA Supercare	**Rate**	$777.73	$1,748.02	$1,942.08		$1,537	$424,236
Teachers Pak C		**Census**	36	45	138			
	MESSA Choices II $10/$20	**Rate**	$682.32	$1,533.34	$1,703.55		$1,501	$3,943,845
Secretaries Pak A		**Census**			4			
	MESSA Supercare	**Rate**	$786.44	$1,767.62	$1,963.84		$1,964	$94,264
Secretaries Pak C		**Census**	7	35	14			
	MESSA Choices II $10/$20	**Rate**	$682.32	$1,533.34	$1,703.55		$1,470	$987,514
Psychologists		**Census**	1	1	2			
	MESSA Supercare	**Rate**	$793.57	$1,783.66	$1,981.68		$1,635	$78,487
Administrative and Non-Affiliated		**Census**	4	8	12			
	BCBSM Flexible Blue 2 (Current HSA)	**Rate**	$568.32	$1,363.94	$1,704.94	$55,000	$1,593	$458,729
		TOTALS:	55	95	180	**330**	$1,512	**$5,987,075**

	Equivalent Rates (Including Deductible Funding and Fees as Applicable)					Estimated	Worst Case
Product Name	**1P**	**2P**	**FF**	**Composite**	**Total Cost**	**Annual Savings**	**Exposure**
BCBSM Flexible Blue HSA Products 100% Rx (ERS Only)							
BCBSM Flexible Blue 2 (Current HSA)	$796	$1,911	$2,388	$1,986	$7,862,653	-$1,875,578	$7,862,653
BCBSM Flexible Blue 2 (Current HRA)	$785	$1,883	$2,354	$1,957	$7,749,216	-$1,762,140	$7,862,653
BCBSM FB2-0 100% Rx HSA	$796	$1,911	$2,388	$1,986	$7,862,653	-$1,875,578	$7,862,653
BCBSM Flexible Blue 3 (Current HSA)	$775	$1,860	$2,326	$1,933	$7,655,644	-$1,668,569	$7,655,644
BCBSM Flexible Blue 3 (Current HRA)	$745	$1,787	$2,234	$1,857	$7,353,144	-$1,366,069	$7,655,644
BCBSM FB3-0 100% Rx HSA	$775	$1,860	$2,326	$1,933	$7,655,644	-$1,668,569	$7,655,644
BCBSM FB4-0 100% Rx HSA	$738	$1,771	$2,214	$1,840	$7,287,637	-$1,300,562	$7,287,637
MESSA Plans	Declined						
Priority Health Conventional PPO Plans							
Priority Health PPO 1 $10/$20 Rx	$577	$1,298	$1,442	$1,256	$4,974,781	$1,012,295	$4,974,781
Priority Health HSA PPO Plans							
Priority Health PPO HSA Min Plan $0/$0 Rx	$477	$1,072	$1,191	$1,038	$4,108,568	$1,878,507	$4,108,568
Priority Health HSA PPO Combined Deductible Plans							
Priority Health PPO HSA Combined Deductible Min Plan $0/$0 Rx	$481	$1,080	$1,200	$1,046	$4,140,943	$1,846,133	$4,140,943
EHIM CB SMRP w BCBSM Rx							
BCBSM/EHIM CB15-0 to First Dollar Insured $10/$20 Rx	$644	$1,546	$1,864	$1,569	$6,213,892	-$226,816	$6,894,517
BCBSM/EHIM CB15-0 to First Dollar Insured $5/$25/$50 Rx	$582	$1,396	$1,745	$1,451	$5,745,154	$241,922	$6,425,779
BCBSM/EHIM CB15-0 to School Plan II Insured $10/$20 Rx	$639	$1,533	$1,848	$1,556	$6,161,642	-$174,566	$6,993,517

Product Name	Equivalent Rates (Including Deductible Funding and Fees as Applicable) 1P	2P	FF	Composite	Total Cost	Estimated Annual Savings	Worst Case Exposure
BCBSM/EHIM CB15-0 to School Plan II Insured $5/$25/$50 Rx	$592	$1,420	$1,775	$1,476	$5,844,154	$142,922	$6,524,779
HAP PPO Conventional Plans							
HAP PPO Con-0%; $0 ded; $5 ov; $10/$20/$20 Rx	$702	$1,580	$1,896	$1,606	$6,358,820	-$371,744	$6,358,820
HAP PPO Con-0%; $100/$200 ded; $5 ov; $10/$20/$20 Rx	$696	$1,566	$1,879	$1,592	$6,302,405	-$315,330	$6,302,405

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Medical Plan Disclaimers:

Please take note of the following disclaimers if you are interested in a Blue Cross Blue Shield of Michigan plan shown within this proposal.

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

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

BCBSB 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 MM65 is part of your coverage, Master Medical will no longer be a part of your Medicare supplemental coverage.

Cost includes a 7% rate load for groups with less than 10 employees.
ERS specific:

BCBSM reserves the right to requote if enrollment or membership mix changes by greater than ten percent variance from the proposal assumptions. A final proposal may be completed once actual enrollment and benefit selections are known.

The ERS rates represent a formula III fully insured arrangement. The rates may also be used for illustrative purposes for a self-funded program.

ERS proposal may not be used to price the ERS 50-99 product.

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Medical Plan Disclaimers:

Please take note of the following disclaimers if you are interested in a Blue Cross Blue Shield of Michigan plan using EHIM as the Third Party Administrator.

EHIM

One time set-up fees are not included in the rates above. Medical plan set-up: $1,000; Debit card set-up: $500; Debit cards issued: $3.00 per card.

Monthly administration fees are included in the rates above. ($500 minimum monthly administration fees for new business)

The above projections do not account for Run-in claims processed on behalf of the previous carrier.

Drugs not covered under the carrier formulary may be paid for with use of the Debit Card. This may increase the overall plan cost.

Employees are responsible for presenting the primary insurance card prior to the use of the debit card. Claims paid for with the debit card are not transferred to the primary insurance deductible.

Credit for drug claims within the primary carriers deductible that are paid for with the use of the Debit Card cannot be guaranteed.

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Medical Plan Disclaimers:

Please take note of the following disclaimers if you are interested in a Priority Health plan shown within this proposal.

PriorityHealth

Priority Health HSA plans post-deductible co-insurance only applies to a small number of services not covered at 100%. These services include TMJ, Orthognathic surgeries, other certain surgeries, and treatment for morbid obesity. Please refer to plan summary for details.

Final premium rates will vary slightly due to rounding.

Rates and benefit summaries may be pending and subject to approval by the Michigan Office of Financial and Insurance Regulation

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

Priority Health's POS plans may not coexist with other carriers.

If two Priority Health plan designs coexist, there must be two or more differences in preferred base coinsurance, deductible, office visit copay, and/or Rx copay. Five or more must enroll in each offered plan design.

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.

Small Group Specific:

1-10 Eligible Employees: 100% of eligible employees seeking coverage must participate. (One subscriber plans not available in East Region)

11-25 Eligible Employees: 75% of eligible employees seeking coverage must participate.

26-50 Eligible Employees: 50% of eligible employees seeking coverage must participate.

All groups with 2-50 Eligible Employees: Groups with a COBRA class are eligible if the participants make up less than 10% of the employees seeking coverage with PH. Retirees are

Benefit Summaries

Prepared for Royal Oak Public Schools

Community Blue[SM] PPO – Plan 15/0% w/MHP

Benefits-at-a-Glance - See Optional Riders for modifications to Standard Benefit Description

Packaged Riders: CB-OV$40, CB-ET$250, CB-PCM$500

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 to covered services. For a complete description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificates and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by your plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and will be construed under the jurisdiction of and according to the laws of the state of Michigan.

	In-network	Out-of-network**
Member's responsibility (deductibles, copays and dollar maximums)		
Deductibles	$2,500 for one member, $5.000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Deductible may be waived if service is performed in a PPO physicians's office.	$5,000 for one member, $10,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network deductible amounts also apply toward the in-network deductible.
Copays		
• Fixed dollar copays	• $40 copay for office visits • $250 copay for emergency room visits	$250 copay for emergency room visits
• Percent copays	• 50% of approved amount for private duty nursing	• 50% of approved amount for private duty nursing • 20% of approved amount for most other covered services
	See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copay amounts.	See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copay amounts.
Copay dollar maximums – applies to copays for all covered services – including mental health and substance abuse services – but **does not** apply to fixed dollar copays and private duty nursing percent copays **Note:** For groups with 50 or fewer employees or groups that are **not** subject to the MHP law, mental health care and substance abuse treatment copays **do not** contribute to the copay dollar maximum.	Not applicable	$5,000 for one member, $10,000 for two or more members each calendar year
Dollar maximums	None	

** 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.

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	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) • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	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) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent copay.	60% after out-of-network deductible **Note:** 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 routine colonoscopy (no deductible or copay) **Note:** Subsequent medically necessary colonoscopies performed during the same calendar year are subject to your deductible and percent copay.	60% after out-of-network deductible
	One routine colonoscopy per member per calendar year	
Physician office services		
Office visits	Covered - $40 copay per office visit	Covered - 80% after deductible, must be medically necessary
Outpatient and home medical care visits	Covered – 100% after deductible	Covered – 80% after deductible, must be medically necessary
Office consultations	Covered - $40 copay per office visit	Covered - 80% after deductible, must be medically necessary
Urgent care visits	Covered - $40 copay per office visit	Covered - 80% after deductible, must be medically necessary

** 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.

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Emergency medical care	In-network	Out-of-network**
Hospital emergency room	Covered – $250 copay per visit (copay waived if admitted or for an accidental injury)	Covered – $250 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services – must be medically necessary	Covered – 100% after deductible	Covered – 100% after deductible
Diagnostic services		
Laboratory and pathology services	Covered – 100% after deductible	Covered – 80% after deductible
Diagnostic tests and x-rays	Covered – 100% after deductible	Covered – 80% after deductible
Therapeutic radiology	Covered – 100% after deductible	Covered – 80% after deductible
Maternity services provided by a physician		
Prenatal and postnatal care	Covered – 100%	Covered – 80% after deductible
	Includes covered services provided by a certified nurse midwife	
Delivery and nursery care	Covered – 100% after deductible	Covered – 80% after deductible
	Includes covered services provided by a certified nurse midwife	
Hospital care		
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies	Covered – 100% after deductible	Covered – 80% after deductible
Note: Nonemergency services must be rendered in a **participating** hospital.	Unlimited days	
Inpatient consultations	Covered – 100% after deductible	Covered – 80% after deductible
Chemotherapy	Covered – 100% after deductible	Covered – 80% after deductible
Alternatives to hospital care		
Skilled nursing care	Covered – 100% after deductible	Covered – 100% after deductible
	Up to 120 days per calendar year per member	
Hospice care	Covered – 100%	Covered – 100%
	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	
Home health care – must be medically necessary	Covered – 100% after deductible	Covered – 100% after deductible
Home infusion therapy – must be medically necessary	Covered – 100% after deductible	Covered – 100% after deductible
Surgical services		
Surgery – includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	Covered – 100% after deductible	Covered – 80% after deductible
Presurgical consultations	Covered – 100%	Covered – 80% after deductible
Colonoscopy	Covered – 100% after deductible	Covered – 80% after deductible
Voluntary sterilization	Covered – 100% after deductible	Covered – 80% after deductible

** 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.

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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 (800-242-3504)	Covered – 100%	Covered – in designated facilities **only**
	Limited to $1 million **lifetime** maximum per member per transplant type for transplant procedure(s) and related professional, hospital and pharmacy services	
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 100% after deductible	Covered – 80% after deductible
Specified oncology clinical trials	Covered – 100% after deductible	Covered – 80% after deductible
Kidney, cornea and skin transplants	Covered – 100% after deductible	Covered – 80% after 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 care and substance abuse treatment are subject to the following copays. Your copays for mental health care and substance abuse treatment are subject to a separate, combined annual copay dollar maximum. See "Copay dollar maximums" section for these amounts. If you are employed by a union group with a collective bargaining agreement, please contact your employer to determine if this benefit level applies to you.		
Inpatient mental health care	Covered – 100% after deductible	Covered – 80% after deductible
	Unlimited days	
Inpatient substance abuse treatment	Covered – 100% after deductible	Covered – 80% after deductible
	Unlimited days	
Outpatient mental health care		
• Facility and clinic	Covered – 100% after deductible	Covered – 100% after deductible
• Physician's office	Covered – 100% after deductible	Covered – 80% after deductible
Outpatient substance abuse treatment – in approved facilities **only**	Covered – 100% after deductible	Covered – 100% after deductible
Note: If your employer has **50 or fewer** employees (all employees, not just eligible employees) and is subject to the MHP law, covered mental health care and substance abuse treatment are subject to the following copays. Your copays for mental health care and substance abuse treatment are not limited to a copay dollar maximum. If you are employed by a union group with a collective bargaining agreement, please contact your employer to determine if this benefit level applies to you.		
Inpatient mental health care	Covered – 50% after deductible	Covered – 50% after deductible
	Unlimited days	
Inpatient substance abuse treatment	Covered – 50% after deductible	Covered – 50% after deductible
	Unlimited days, up to $15,000 annual, $30,000 lifetime maximum	
Outpatient mental health care		
• Facility and clinic	Covered – 50% after deductible	Covered – 50% after deductible
• Physician's office	Covered – 50%	Covered – 50% after deductible
Outpatient substance abuse treatment – in approved facilities **only**	Covered – 50% after deductible	Covered – 50% after deductible
	Up to the state-dollar amount that is adjusted annually	

** 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.

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	In-network	Out-of-network**
Other covered services		
Outpatient Diabetes Management Program (ODMP)	Covered – 100% after deductible	Covered – 80% after deductible
Allergy testing and therapy	Covered – 100%	Covered – 80% after deductible
Chiropractic manipulation treatment and osteopathic manipulation treatment	Covered - $40 copay per office visit	Covered - 80% after deductible
	Up to a maximum of 24 visits per member per calendar year	
Outpatient physical, speech and occupational therapy	Covered – 100% after deductible	Covered – 80% after deductible
	Limited to a **combined** maximum of 60 visits per calendar year per member	
Durable medical equipment	Covered – 100% after deductible	Covered – 100% after deductible
Prosthetic and orthotic appliances	Covered – 100% after deductible	Covered – 100% after deductible
Private duty nursing	Covered – 50% after deductible	Covered – 50% after deductible
Prescription drugs	Not covered	Not covered

Optional riders selected	
Rider XVA, Excludes Voluntary Abortions	Excludes benefits for voluntary abortions
Rider CI, Contraceptive Injections, **Rider PCD**, Prescription Contraceptive Devices and **Rider PD-CM**, Prescription Contraceptive Medications	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). **Note:** These riders are available only with prescription drug coverage. Riders CI and PCD are part of your medical-surgical coverage and are subject to the same deductible and copay, if any, you pay for medcial-surgical services. Rider PD-CM is part of your prescription drug coverage and is subject to the same copay you pay for prescription drugs.

** 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.

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Blue Preferred® Rx Prescription Drug Coverage with $5 Generic / $25 Formulary Brand / $50 Nonformulary Brand Triple-Tier Copay Open Formulary Benefits-at-a-Glance - See Optional Riders for modifications to Standard Benefit Description

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 to covered services. For a complete description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificates and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by your plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and will be construed under the jurisdiction of and according to the laws of the state of Michigan.

Specialty Drugs – The mail order pharmacy for **specialty drugs** is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) 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**. 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).

If you are enrolled in one of our integrated medical-surgical prescription drug products, your prescription drug benefits, including mail order drugs, are subject to the same deductible and lifetime dollar maximum required under your medical-surgical coverage. Benefits are not payable until after you have met the annual deductible. After you have satisfied the deductible you are required to pay the copays listed below, which may be limited to an annual out-of-pocket maximum.

		90-day retail network pharmacy	* Network mail order provider	Network pharmacy (not part of the 90-day retail network)	Non-network pharmacy
Member's responsibility (copays)					
Tier 1 – Generic or prescribed over-the-counter drugs	1 to 30 day period	$5 copay	$5 copay	$5 copay	$5 copay ***plus*** 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
Tier 2 – Formulary brand-name drugs	1 to 30 day period	$25 copay	$25 copay	$25 copay	$25 copay ***plus*** 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
Tier 3 – Nonformulary brand-name drugs	1 to 30 day period	$50 copay	$50 copay	$50 copay	$50 copay ***plus*** 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				
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 Note: 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	
Mandatory preauthorization	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. **Step Therapy**, 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 **bcbsm.com**. Log in under "I am a Member" and click on "Prescription Drugs."
Mandatory maximum allowable cost (MAC) drugs	If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a generic equivalent drug, you pay only the copay. If you obtain a formulary brand name drug when a generic equivalent drug is available, you **MUST** pay the **difference** in cost between the formulary brand name drug dispensed and the maximum allowable cost for the generic drug ***plus*** your copay regardless of whether you or your doctor requests the formulary brand name drug. If you obtain a nonformulary brand-name drug when a generic equivalent is available, the nonformulary brand-name drug is not a covered benefit. **Exception:** If your physician requests and receives authorization for a nonformulary 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.
Physician-administered injectable drugs	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.
Drug interchange and generic copay waiver	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 **bcbsm.com**. 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.
Quantity limits	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 **bcbsm.com**.

Optional riders selected	
Rider CI, Contraceptive Injections, **Rider PCD**, Prescription Contraceptive Devices and **Rider PD-CM**, Prescription Contraceptive Medications	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). **Note:** These riders are available only with prescription drug coverage. Riders CI and PCD are part of your medical-surgical coverage and are subject to the same deductible and copay, if any, you pay for medcial-surgical services. Rider PD-CM is part of your prescription drug coverage and is subject to the same copay you pay for prescription drugs.

Prepared for Royal Oak Public Schools

Community Blue℠ PPO – Plan 15/20% w/MHP Benefits-at-a-Glance - See Optional Riders for modifications to Standard Benefit Description

Packaged Riders: CB-OV$40, CB-ET$250, CB-PCM$500

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 to covered services. For a complete description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificates and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by your plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and will be construed under the jurisdiction of and according to the laws of the state of Michigan.

	In-network	Out-of-network**
Member's responsibility (deductibles, copays and dollar maximums)		
Deductibles	$2,500 for one member, $5,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Deductible may be waived if service is performed in a PPO physicians's office.	$5,000 for one member, $10,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network deductible amounts also apply toward the in-network deductible.
Copays		
• Fixed dollar copays	• $40 copay for office visits • $250 copay for emergency room visits	$250 copay for emergency room visits
• Percent copays	• 50% of approved amount for private duty nursing • 20% of approved amount for most other covered services (copay waived if service is performed in a PPO physician's office)	• 50% of approved amount for private duty nursing • 40% of approved amount for most other covered services
	See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copay amounts.	See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copay amounts.
Copay dollar maximums – applies to copays for all covered services – including mental health and substance abuse services – but **does not** apply to fixed dollar copays and private duty nursing percent copays **Note:** For groups with 50 or fewer employees or groups that are **not** subject to the MHP law, mental health care and substance abuse treatment copays **do not** contribute to the copay dollar maximum.	$2,500 for one member, $5,000 for two or more members each calendar year	$5,000 for one member, $10,000 for two or more members each calendar year **Note:** Out-of-network copays also apply toward the in-network maximum.
Dollar maximums	None	

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	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) • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	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) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent copay.	60% after out-of-network deductible **Note:** 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 routine colonoscopy (no deductible or copay) **Note:** Subsequent medically necessary colonoscopies performed during the same calendar year are subject to your deductible and percent copay.	60% after out-of-network deductible
	One routine colonoscopy per member per calendar year	
Physician office services		
Office visits	Covered - $40 copay per office visit	Covered - 60% after deductible, must be medically necessary
Outpatient and home medical care visits	Covered – 80% after deductible	Covered – 60% after deductible, must be medically necessary
Office consultations	Covered - $40 copay per office visit	Covered - 60% after deductible, must be medically necessary
Urgent care visits	Covered - $40 copay per office visit	Covered - 60% after deductible, must be medically necessary

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Emergency medical care	In-network	Out-of-network**
Hospital emergency room	Covered – $250 copay per visit (copay waived if admitted or for an accidental injury)	Covered – $250 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services – must be medically necessary	Covered – 80% after deductible	Covered – 80% after deductible
Diagnostic services		
Laboratory and pathology services	Covered – 80% after deductible	Covered – 60% after deductible
Diagnostic tests and x-rays	Covered – 80% after deductible	Covered – 60% after deductible
Therapeutic radiology	Covered – 80% after deductible	Covered – 60% after deductible
Maternity services provided by a physician		
Prenatal and postnatal care	Covered – 100%	Covered – 60% after deductible
	Includes covered services provided by a certified nurse midwife	
Delivery and nursery care	Covered – 80% after deductible	Covered – 60% after deductible
	Includes covered services provided by a certified nurse midwife	
Hospital care		
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies	Covered – 80% after deductible	Covered – 60% after deductible
Note: Nonemergency services must be rendered in a **participating** hospital.	Unlimited days	
Inpatient consultations	Covered – 80% after deductible	Covered – 60% after deductible
Chemotherapy	Covered – 80% after deductible	Covered – 60% after deductible
Alternatives to hospital care		
Skilled nursing care	Covered – 80% after deductible	Covered – 80% after deductible
	Up to 120 days per calendar year per member	
Hospice care	Covered – 100%	Covered – 100%
	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	
Home health care – must be medically necessary	Covered – 80% after deductible	Covered – 80% after deductible
Home infusion therapy – must be medically necessary	Covered – 80% after deductible	Covered – 80% after deductible
Surgical services		
Surgery – includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	Covered – 80% after deductible	Covered – 60% after deductible
Presurgical consultations	Covered – 100%	Covered – 60% after deductible
Colonoscopy	Covered - 80% after deductible	Covered – 60% after deductible
Voluntary sterilization	Covered – 80% after deductible	Covered – 60% after 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 (800-242-3504)	Covered – 100%	Covered – in designated facilities **only**
	Limited to $1 million **lifetime** maximum per member per transplant type for transplant procedure(s) and related professional, hospital and pharmacy services	
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 80% after deductible	Covered – 60% after deductible
Specified oncology clinical trials	Covered – 80% after deductible	Covered – 60% after deductible
Kidney, cornea and skin transplants	Covered – 80% after deductible	Covered – 60% after 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 care and substance abuse treatment are subject to the following copays. Your copays for mental health care and substance abuse treatment are subject to a separate, combined annual copay dollar maximum. See "Copay dollar maximums" section for these amounts. If you are employed by a union group with a collective bargaining agreement, please contact your employer to determine if this benefit level applies to you.		
Inpatient mental health care	Covered – 80% after deductible	Covered – 60% after deductible
	Unlimited days	
Inpatient substance abuse treatment	Covered – 80% after deductible	Covered – 60% after deductible
	Unlimited days	
Outpatient mental health care		
• Facility and clinic	Covered – 80% after deductible	Covered – 80% after deductible
• Physician's office	Covered – 80% after deductible	Covered – 60% after deductible
Outpatient substance abuse treatment – in approved facilities **only**	Covered – 80% after deductible	Covered – 80% after deductible
Note: If your employer has **50 or fewer** employees (all employees, not just eligible employees) and is subject to the MHP law, covered mental health care and substance abuse treatment are subject to the following copays. Your copays for mental health care and substance abuse treatment are not limited to a copay dollar maximum. If you are employed by a union group with a collective bargaining agreement, please contact your employer to determine if this benefit level applies to you.		
Inpatient mental health care	Covered – 50% after deductible	Covered – 50% after deductible
	Unlimited days	
Inpatient substance abuse treatment	Covered – 50% after deductible	Covered – 50% after deductible
	Unlimited days, up to $15,000 annual, $30,000 lifetime maximum	
Outpatient mental health care		
• Facility and clinic	Covered – 50% after deductible	Covered – 50% after deductible
• Physician's office	Covered – 50%	Covered – 50% after deductible
Outpatient substance abuse treatment – in approved facilities **only**	Covered – 50% after deductible	Covered – 50% after 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)	Covered – 80% after deductible	Covered – 60% after deductible
Allergy testing and therapy	Covered – 100%	Covered – 60% after deductible
Chiropractic manipulation treatment and osteopathic manipulation treatment	Covered - $40 copay per office visit	Covered - 60% after deductible
	Up to a maximum of 24 visits per member per calendar year	
Outpatient physical, speech and occupational therapy	Covered – 80% after deductible	Covered – 60% after deductible
	Limited to a **combined** maximum of 60 visits per calendar year per member	
Durable medical equipment	Covered – 80% after deductible	Covered – 80% after deductible
Prosthetic and orthotic appliances	Covered – 80% after deductible	Covered – 80% after deductible
Private duty nursing	Covered – 50% after deductible	Covered – 50% after deductible
Prescription drugs	Not covered	Not covered

Optional riders selected	
Rider XVA, Excludes Voluntary Abortions	Excludes benefits for voluntary abortions
Rider CI, Contraceptive Injections, **Rider PCD**, Prescription Contraceptive Devices and **Rider PD-CM**, Prescription Contraceptive Medications	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). **Note:** These riders are available only with prescription drug coverage. Riders CI and PCD are part of your medical-surgical coverage and are subject to the same deductible and copay, if any, you pay for medcial-surgical services. Rider PD-CM is part of your prescription drug coverage and is subject to the same copay you pay for prescription drugs.

** 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.

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Specialty Drugs – The mail order pharmacy for **specialty drugs** is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) 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**. 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).

If you are enrolled in one of our integrated medical-surgical prescription drug products, your prescription drug benefits, including mail order drugs, are subject to the same deductible and lifetime dollar maximum required under your medical-surgical coverage. Benefits are not payable until after you have met the annual deductible. After you have satisfied the deductible you are required to pay the copays listed below, which may be limited to an annual out-of-pocket maximum.

		90-day retail network pharmacy	* Network mail order provider	Network pharmacy (not part of the 90-day retail network)	Non-network pharmacy
Member's responsibility (copays)					
Tier 1 – Generic or prescribed over-the-counter drugs	1 to 30 day period	$5 copay	$5 copay	$5 copay	$5 copay ***plus*** 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
Tier 2 – Formulary brand-name drugs	1 to 30 day period	$25 copay	$25 copay	$25 copay	$25 copay ***plus*** 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
Tier 3 – Nonformulary brand-name drugs	1 to 30 day period	$50 copay	$50 copay	$50 copay	$50 copay ***plus*** 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				
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 Note: Needles and syringes have no copay.	100% of approved amount less plan copay for the insulin or other covered injectablelegenddrug	100% of approved amount less plan copay for the insulin or other covered injectablelegenddrug	100% of approved amount less plan copay for the insulin or other covered injectablelegenddrug	75% of approved amount less plan copay for the insulin or other covered injectablelegenddrug

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

Features of your prescription drug plan	
Mandatory preauthorization	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. **Step Therapy**, 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 **bcbsm.com**. Log in under "I am a Member" and click on "Prescription Drugs."
Mandatory maximum allowable cost (MAC) drugs	If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a generic equivalent drug, you pay only the copay. If you obtain a formulary brand name drug when a generic equivalent drug is available, you **MUST** pay the **difference** in cost between the formulary brand name drug dispensed and the maximum allowable cost for the generic drug ***plus*** your copay regardless of whether you or your doctor requests the formulary brand name drug. If you obtain a nonformulary brand-name drug when a generic equivalent is available, the nonformulary brand-name drug is not a covered benefit. **Exception:** If your physician requests and receives authorization for a nonformulary 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.
Physician-administered injectable drugs	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.
Drug interchange and generic copay waiver	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 **bcbsm.com**. 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.
Quantity limits	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 **bcbsm.com**.

Optional riders selected	
Rider CI, Contraceptive Injections, **Rider PCD**, Prescription Contraceptive Devices and **Rider PD-CM**, Prescription Contraceptive Medications	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). **Note:** These riders are available only with prescription drug coverage. Riders CI and PCD are part of your medical-surgical coverage and are subject to the same deductible and copay, if any, you pay for medical-surgical services. Rider PD-CM is part of your prescription drug coverage and is subject to the same copay you pay for prescription drugs.

PriorityHealth

Benefit Summary
PriorityHSA℠ - PPO
ROYAL OAK PUBLIC SCHOOLS
Date 12/1/2010 – 11/30/2011
100% Network — 80% Non-Network

The PriorityHSA℠- PPO plan offers you a choice of two benefit levels. The Network Benefits level applies when you use a Network provider. Your out-of-pocket costs are lower when you use this option. The Non-Network level applies when you seek medical services from a Non-Network provider.

The following information is provided as a summary of benefits available under your PriorityHSA℠- PPO plan. This summary is not intended as a substitute for your Policy and Schedule of Benefits. It is not a binding contract. Limitations and exclusions apply to benefits listed below. A complete listing of covered services, limitations and exclusions is contained in the Policy, Schedule of Benefits and any applicable Addenda issued to you. You may request a copy of the Policy from Priority Health's Customer Service Department at 616 464-8830 or 888 389-6645 or on our web site priorityhealth.com. Contact Priority Health's Customer Service Department if you have questions about your benefits or Coverage.

PRIOR APPROVAL

Prior approval is required before you may obtain certain services. If you seek services that require prior approval, without receiving prior approval from us, you will receive a reduction in benefit coverage for those services. You will also be responsible for those services that are beyond those approved, beyond the benefit maximums or excluded from Coverage.

You or your physician must call 800 269-1260 to obtain prior approval for services. Emergency admissions must be notified to us as soon as reasonably possible after admission.

DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS

A. Deductibles:

The Deductible is the amount of Covered Services you must incur during the Contract Year before benefits will be paid. The Network Benefits Deductible is applicable to all Covered Services received under the Network Benefit level except:

- Routine obstetrical services (deductible will apply to delivery).
- Preventive health services that are listed in Priority Health's Preventive Health Care Guidelines.

The Non-Network Benefits Deductible is applicable to all Covered Services received under the Non-Network Benefit level or received from Non-Network providers.

The Network and Non-Network Benefits Deductibles are calculated separately.

If you are the only individual on your contract, you have an Individual Contract and the Individual Contract Deductibles apply. If you have more than one individual on your contract, you have a Family Contract and only the Family Contract Deductibles apply. The Family Contract Deductibles can be satisfied by any one family member or by any combination of family members.

The Network and Non-Network Benefits Deductibles renew each Contract Year. This plan does not carry over any Deductible amounts incurred in the prior Contract Year.

The Network Benefits Deductible will include any monies paid for Covered Pharmacy Services.

Notwithstanding the above, the following costs are not credited towards any of the Deductibles: costs for services that exceed the annual day or dollar benefit maximum for a specific benefit (denied as non-Covered Services); penalties for failure to preauthorize services; or, any amounts paid by member for Non-Network Benefits that exceed Reasonable and Customary.

Deductibles	Network Benefits	Non-Network Benefits
Individual Contract	$1,200.00	$3,000.00
Family Contract	$2,400.00	$6,000.00

B. Out-of-Pocket Maximums:

The Out-of-Pocket maximum limits the total amount of covered expenses that you and/or your covered dependents will pay during a Contract Year.

Once the Network Benefits Out-of-Pocket maximum is met, all further Covered medical and pharmacy services incurred at the Network Benefits level will be paid at 100% of Priority Health's contracted rate for the remainder of the Contract Year.

Once the Non-Network Benefits Out-of-Pocket maximum is met, all further Covered medical services incurred at the Non-Network Benefits level will be paid at 100% of the lesser of billed charges or Reasonable and Customary charges for the remainder of the Contract Year.

If you have an Individual Contract, all Copayments, Coinsurance and Deductibles you paid towards Covered Services during the Contract Year will be included when calculating your Out-of-Pocket maximums. If you have a Family Contract, all Copayments, Coinsurance and Deductibles you and/or your covered family members paid collectively towards Covered Services during the Contract Year will be included when calculating your Out-of-Pocket maximums.

Notwithstanding the above, the following costs are not credited towards the Out-of-Pocket maximums: costs for services that exceed the annual day or dollar benefit maximum for a specific benefit (denied as non-Covered Services); penalties for failure to preauthorize services; or, any amounts paid by member for Non-Network Benefits that exceed Reasonable and Customary.

Note that if the non-notification penalty applies, the amount Priority Health pays will be reduced regardless of whether the Out-of-Pocket maximum has been reached.

Out-of-Pocket Maximums	Network Benefits	Non-Network Benefits
Individual Contract	$2,000.00	$4,000.00
Family Contract	$4,000.00	$8,000.00

The Network Benefits Out-of-Pocket Maximums do not apply to the Non-Network Benefits Out-of-Pocket Maximums, nor do the Non-Network Benefits Out-of-Pocket Maximums apply to the Network Benefits Out-of-Pocket Maximums.

C. Maximum Individual Annual Benefit:

$5,000,000.00 is the combined annual benefit per insured for all Network and Non-Network covered services. (Any reduction in benefits/penalty will apply to the maximum individual annual benefit.)

Covered Benefits

Benefits	Network Benefits	Non-Network Benefits
Preventive Health Services	• 100% Coverage • Deductible does not apply	• 80% Coverage of Reasonable and Customary Charges • Deductible applies
PHYSICIAN SERVICES		
Office and Home Visits (evaluation and management services only)	• 100% Coverage • Deductible applies	• 80% Coverage of Reasonable and Customary Charges for face-to-face visits only • Deductible applies
Inpatient Hospital Visits	• 100% Coverage • Deductible applies	• 80% Coverage of Reasonable and Customary Charges • Deductible applies
Surgery	• 100% Coverage • Deductible applies	• 80% Coverage of Reasonable and Customary Charges • Deductible applies
Ambulatory Surgery Center Services	• 100% Coverage for physician surgical charges • Deductible applies	• 80% Coverage of Reasonable and Customary Charges • Deductible applies
Obstetrical Services (Routine prenatal delivery and postnatal evaluation and management services only)	• 100% Coverage for routine prenatal and postnatal services • Deductible does not apply to routine prenatal and postnatal services • Deductible applies to delivery	• 80% Coverage of Reasonable and Customary Charges • Deductible applies
Vasectomy	• 100% Coverage for Physician services when performed in a physician's office or when in connection with other Covered inpatient or outpatient surgery • 100% Coverage for outpatient and inpatient facility charges only when in connection with other Covered inpatient and outpatient surgery • Deductible applies	• 80% Coverage for Physician services when performed in a physician's office or when in connection with other Covered inpatient or outpatient surgery • 80% Coverage for outpatient and inpatient facility charges only when in connection with other Covered inpatient and outpatient surgery • Deductible applies
Tubal Ligation	• 100% Coverage for Physician services • 100% Coverage for outpatient facility charges • 100% Coverage for inpatient facility charges only when in connection with delivery or other Covered inpatient surgery • Deductible applies	• 80% Coverage for Physician services • 80% Coverage for outpatient facility charges • 80% Coverage for inpatient facility charges only when in connection with delivery or other Covered inpatient surgery • Deductible applies

Benefits	Network Benefits	Non-Network Benefits
Physician Services (continued)		
Consultations, pre-operative and post-operative visits (Evaluation and management services only)	• 100% Coverage • Deductible applies	• 80% Coverage of Reasonable and Customary Charges • Deductible applies
Allergy Testing	• 100% Coverage • Deductible applies	• 80% Coverage of Reasonable and Customary Charges • Deductible applies
Allergy Injections	• 100% Coverage • Deductible applies	• 80% Coverage of Reasonable and Customary Charges • Deductible applies
Family Planning	• 100% Coverage • Deductible applies	• 80% Coverage of Reasonable and Customary Charges • Deductible applies
Infertility Services (Covered for diagnosis and treatment of underlying cause only)	• 100% Coverage • Deductible applies	• 80% Coverage of Reasonable and Customary Charges • Deductible applies
Temporomandibular Joint Dysfunction or Syndrome	• 50% Coverage (including physicians' fees and any other related charges) • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies	• 50% Coverage (including physicians' fees and any other related charges) of Reasonable and Customary Charges • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies
Orthognathic Surgery	• 50% Coverage (including physicians' fees and any other related charges) • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies	• 50% Coverage (including physicians' fees and any other related charges)of Reasonable and Customary Charges • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies

Benefits	Network Benefits	Non-Network Benefits
Physician Services (continued)		
Certain Surgeries and Treatments (Physician fees only) Reconstructive surgery: blepharoplasty of upper lids, breast reduction, panniculectomy*, rhinoplasty*, septorhinoplasty* and surgical treatment of male gynecomastia **Skin Disorder Treatments**: Scar revision, keloid scar treatment, treatment of hyperhidrosis, excision of lipomas, excision of seborrheic keratoses, excision of skin tags, treatment of vitiligo and port wine stain and hemangioma treatment Varicose veins treatments Sleep apnea treatment procedures*	• Physician fees are Covered at 50%, of the first $2,000.00 for each certain surgery or treatment, 100% thereafter. • Prior approval required for blepharoplasty, breast reduction, panniculectomy, rhinoplasty, septorhinoplasty and sleep apnea treatment. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies	• Physician fees are Covered at 50% of the first $2,000.00 of Reasonable and Customary Charges for each certain surgery or treatment, 100% thereafter. • Prior approval required for blepharoplasty, breast reduction, panniculectomy, rhinoplasty, septorhinoplasty and sleep apnea treatment. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies
Treatment of Morbid Obesity • Weight loss programs • Bariatric surgery – limit one per lifetime	• Physician's fees for treatment of morbid obesity is Covered at 50% of the first $2,000.00, 100% thereafter to lifetime maximum benefit of $25,000.00 • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies	• Physician's fees for treatment of morbid obesity is Covered at 50% of the first $2,000.00 of Reasonable and Customary Charges, 100% thereafter to lifetime maximum benefit of $25,000.00 • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies
HOSPITAL SERVICES (Including radiology examinations and laboratory services)		
Inpatient Hospital Services (Including observation care, transplants and maternity stays for a mother and her Newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section)	• 100% Coverage • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Notification required for admissions following emergency room care • Deductible applies	• 80% Coverage of Reasonable and Customary Charges • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Notification required for admissions following emergency room care • Deductible applies
Outpatient Hospital Services (Including ambulatory surgery center facility charges)	• 100% Coverage • Some services may require prior approval • Deductible applies	• 80% Coverage of Reasonable and Customary Charges • Some services may require prior approval • Deductible applies

Benefits	Network Benefits	Non-Network Benefits
Medical Emergency and Urgent Care Services		
Emergency Room Services	• 100% Coverage per visit. (Copayment waived only if you become confined as an inpatient in a Hospital.) Emergency Room physician, ancillary and special services are Covered in full. • Deductible applies	• 100% Coverage per visit. (Copayment waived only if you become confined as an inpatient in a Hospital). • Deductible applies
Urgent Care Facility Services	• 100% Coverage per visit (Copayment applies to all Urgent Care visits) • Deductible applies	• 100% Coverage of Reasonable and Customary Charges • Deductible applies
Ambulance Services	• 100% Coverage • Deductible applies	• 100% Coverage • Deductible applies
Behavioral Health Prior approval by our Behavioral Health Department is required as noted. Call 616 464-8500 or 800 673-8043		
Mental Health and Substance Abuse Inpatient (including partial hospitalization)	• 100% Coverage • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies	• 80% Coverage of Reasonable and Customary Charges • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies
Mental Health and Substance Abuse Outpatient	• 100% Coverage per visit, including med management • Deductible applies	• 80% Coverage of Reasonable and Customary Charges per visit • Deductible applies

Benefits	Network Benefits	Non-Network Benefits
OTHER SERVICES		
Radiology Examinations and Laboratory Procedures	• 100% Coverage • High-tech imaging services require prior approval. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies	• 80% Coverage of Reasonable and Customary Charges • High-tech imaging services require prior approval. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies
Prosthetic and Orthotics/Support Devices	• 90% Coverage • Prior approval required for devices over $1,000.00 • Deductible applies	• 50% Coverage of Reasonable and Customary Charges • Prior approval required for devices over $1,000.00 • Deductible applies
Durable Medical Equipment (Rent, purchase or repair)	• 90% Coverage • Prior approval required for devices over $1,000.00 • Deductible applies	• 50% Coverage of Reasonable and Customary Charges • Prior approval required for devices over $1,000.00 • Deductible applies
Facility Services (Non-hospital) • Skilled Nursing • Subacute • Inpatient Rehabilitation • Hospice	• 100% Coverage up to the benefit maximum of 45 days per Contract Year* • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies	• 80% Coverage of Reasonable and Customary Charges up to the benefit maximum of 45 days per Contract Year* • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies
Home Health Care (including Hospice Services, excluding Rehabilitative Medicine) **Note:** Rehabilitative services provided in the home are subject to the limitations of the Rehabilitative Medicine Services benefits described below.	• 100% Coverage • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies	• 80% Coverage of Reasonable and Customary Charges • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies
Advanced Diagnostic Imaging Includes, but is not limited to the following: CT, CTA, MRI, MRA, Nuclear Cardiology Studies and PET scanning. Prior Approval is required for certain radiology examinations.	• 100% coverage per test after deductible. (Copayment waived if performed while confined as an inpatient in a Hospital.)	• 80% coverage per test after deductible. (Copayment waived if performed while confined as an inpatient in a Hospital.)
REHABILITATIVE MEDICINE SERVICES		
Physical and Occupational Therapy (including osteopathic and chiropractic manipulation)	• 100% Coverage per visit up to a combined benefit maximum of 40 visits per Contract Year. • Deductible applies	• 50% Coverage of reasonable and customary charges up to the combined benefit maximum of 40 visits per Contract Year. • Deductible applies
Speech Therapy	• 100% Coverage per visit up to a combined benefit maximum of 40 visits per Contract Year. • Deductible applies	• 50% Coverage of reasonable and customary charges up to the combined benefit maximum of 40 visits per Contract Year. • Deductible applies
Cardiac Rehabilitation and Pulmonary Rehabilitation	• 100% Coverage per visit up to a combined benefit maximum of 40 visits per Contract Year. • Deductible applies	• 50% Coverage of reasonable and customary charges up to the combined benefit maximum of 40 visits per Contract Year. • Deductible applies

Benefits	Network Benefits	Non-Network Benefits
ADDITIONAL BENEFITS		
Prescription Drugs **Note:** Prescription drug coverage is based on the usage of a medication formulary. Deductible applies.	**Tier 1- Generic Drugs** 100% Coverage per prescription or refill for a Generic Drug **Tier 2- Preferred Brand-Name Drugs** 100% Coverage per prescription or refill for a Preferred Brand-Name Drug **Tier 3- Non-Preferred Brand-Name Drugs** 100% Coverage per prescription or refill for a Non-Preferred Brand-Name Drug. Subject to Prior Authorization and/or Step Therapy. **Tier 4- Preferred Specialty Drugs** 100% Coverage for a preferred Specialty Drug. Subject to Prior Authorization and/or Step Therapy. **Tier 5- Non-Preferred Specialty Drugs** 100% Coverage for a non-preferred Specialty Drug. Subject to Prior Authorization and/or Step Therapy. **Infertility Treatment** 50% Copay for drugs used for treating infertility. (Limitations apply) Includes prescription contraceptive drugs and implantable contraceptive drugs. *Contraceptive devices administered or supplied in the physician's office are covered at 50%. Does not cover condoms, foams, jellies, ointments and other drugs or devices available over the counter.*	Not Covered

Prescription Mail Order Filled for up to 90 days Deductible Applies.	**Tier 1- Generic Drugs** 100% Coverage per prescription or refill for a Generic Drug **Tier 2- Preferred Brand-Name Drugs** 100% Coverage per prescription or refill for a Preferred Brand-Name Drug **Tier 3- Non-Preferred Brand-Name Drugs** 100% Coverage per prescription or refill for a Non-Preferred Brand-Name Drug **Tier 4- Preferred Specialty Drugs** Specialty Drugs are limited to a maximum of a 31-day supply per prescription or refill. **Tier 5- Non-Preferred Specialty Drugs** Specialty Drugs are limited to a maximum of a 31-day supply per prescription or refill. Includes prescription contraceptive drugs and implantable contraceptive drugs. (Limitations apply)	Not Covered

ELIGIBILITY INFORMATION		
Dependent Children	• Covered until the end of the year in which dependent turns age 19. Additionally covered between the ages of 19 and 25 if dependent is a full-time student, until dependent is no longer a full-time student or reaches the age of 25.	• Covered until the end of the year in which dependent turns age 19. Additionally covered between the ages of 19 and 25 if dependent is a full-time student, until dependent is no longer a full-time student or reaches the age of 25.
Early Retiree Coverage	Not Available	Not Available
65+ Retiree Coverage	Not Available	Not Available

MAXIMUM LIMITATIONS

A. Benefit Maximums:

* **Benefit Maximums:** Benefit maximums up to a certain number of days/visits/dollar amounts per Contract Year are reached by combining either Network or Non-Network Benefits up to the limit for one or the other, but not both. (Example: If Network Benefits is for 60 visits and Non-Network Benefits is for 60 visits, the maximum benefit is 60 visits, not 120.) Benefit maximums apply even when continued care is Medically/Clinically Necessary beyond the benefit maximum. The Family Out-of-Pocket is not to exceed the Individual Out-of-Pocket maximum per person.

PriorityHealth

Benefit Summary
PriorityPPO℠ Premier
ROYAL OAK PUBLIC SCHOOLS
Date 12/1/2010 – 11/30/2011
100% Network — 80% Non-Network

The PPO plan offers you a choice of two benefit levels. The Network Benefits level applies when you use a Network provider. Your out-of-pocket costs are lower when you use this option. The Non-Network level applies when you seek medical services from a Non-Network provider.

The following information is provided as a summary of benefits available under your PPO plan. This summary is not intended as a substitute for your Policy and Schedule of Benefits. It is not a binding contract. Limitations and exclusions apply to benefits listed below. A complete listing of covered services, limitations and exclusions is contained in the Policy, Schedule of Benefits and any applicable Addenda issued to you. You may request a copy of the Policy from Priority Health's Customer Service Department at 616 464-8830 or 888 389-6645 or on our web site priorityhealth.com. Contact Priority Health's Customer Service Department if you have questions about your benefits or Coverage.

PRIOR APPROVAL

Prior approval is required before you may obtain certain services. If you seek services that require prior approval, without receiving prior approval from us, you will receive a reduction in benefit coverage for those services. You will also be responsible for those services that are beyond those approved, beyond the benefit maximums or excluded from Coverage.

You or your physician must call 800 269-1260 to obtain prior approval for services. Emergency admissions must be notified to us as soon as reasonably possible after admission.

DEDUCTIBLE AND OUT-OF-POCKET MAXIMUMS

A. Deductibles:

The Deductible is the amount of Covered Services you must incur during the Contract Year before benefits will be paid. The Network Benefits Deductible is applicable to all Covered Services except:

- Services with flat dollar copayments.
- Preventive health services, services designated to maintain an individual in optimum health and to prevent unnecessary injury, illness or disability.

The Non-Network Benefit Deductible is applicable to all Covered Services, except for flat dollar copayments, received under the Non-Network Benefit level or received from Non-Network providers.

The Network and Non-Network Deductibles are calculated separately. Deductible amounts you pay, whether under the Network Benefits or Non-Network Benefits, are excluded from any Network or Non-Network Out-of-Pocket Maximums.

The Deductible renews each Contract Year. Any Deductible amount paid under the Network Benefits during the ninety (90) days preceding the start of a new Contract Year will carry over into the new Contract Year. Deductible amounts paid under the Non-Network Benefits do not carry over into a new Contract Year. The Family Deductible is not to exceed the Individual Deductible per person.

Deductibles	Network Benefits	Non-Network Benefits
Individual Contract	Not applicable	$250.00
Family Contract	Not applicable	$500.00

B. Out-of-Pocket Maximums:

The Out-of-Pocket Maximum applies to certain services. The Out-of-Pocket maximum limits the total amount of covered expenses that you and/or your covered dependents will pay during a Contract Year, except as described below.

Out-of-Pocket Maximums	Network Benefits	Non-Network Benefits
Individual	Not applicable	$2,500.00
Family	Not applicable	$5,000.00

The Network Benefits Out-of-Pocket Maximums do not apply to the Non-Network Benefits Out-of-Pocket Maximums, nor do the Non-Network Benefits Out-of-Pocket Maximums apply to the Network Benefits Out-of-Pocket Maximums.

Amounts paid for any of the following will not apply toward the Out-of-Pocket Maximum:

- Any flat dollar Coinsurance, such as Coinsurance for office visits, ambulance and emergency services.
- Penalties
- Deductibles
- Durable medical equipment
- Prosthetic and orthotic/support devices
- Orthognathic surgery
- Temporomandibular joint dysfunction or syndrome
- Port wine stains
- Certain surgeries

After meeting the Out-of-Pocket Maximums, the Coinsurance for these services still apply.

Note:

- Coinsurance made for any Covered Services obtained under a supplemental benefit Addendum may not be applied toward the above Out-of-Pocket Maximum. If your plan has a Deductible, the Deductible amounts you pay will not apply toward the Out-of-Pocket Maximum.

- If the Network or Non-Network Benefits Individual Out-of-Pocket Maximum is reached during a Contract Year, Priority Health will pay 100% of the Reasonable and Customary Charges for Covered Services that apply toward out-of-pocket maximums as incurred by that person for the rest of the Contract Year. If the Network or Non-Network Benefits Family Out-of-Pocket Maximum is reached during a Contract Year, Priority Health will pay 100% of the Reasonable and Customary Charges for Covered Services incurred by you and all your covered dependents for the rest of the Contract Year.

- If the non-notification penalty applies, the amount Priority Health pays will be reduced even if the Out-of-Pocket Maximum has been reached.

C. Maximum Individual Annual Benefit:

$5,000,000.00 is the combined annual benefit per insured for all Network and Non-Network covered services. (Any reduction in benefits/penalty will apply to the maximum individual annual benefit.)

Covered Benefits

Benefits	Network Benefits	Non-Network Benefits
Preventive Health Services	• 100% Coverage	• 80% Coverage of Reasonable and Customary Charges • Deductible applies • Amounts paid after deductible do apply toward out-of-pocket maximums
PHYSICIAN SERVICES		
Office and Home Visits (evaluation and management services only)	• $5.00 Copayment	• 80% Coverage of Reasonable and Customary Charges for face-to-face visits only for face-to-face visits only • Deductible applies • Amounts paid after deductible do apply toward out-of-pocket maximums
Inpatient Hospital Visits	• 100% Coverage	• 80% Coverage of Reasonable and Customary Charges • Deductible applies • Amounts paid after deductible do apply toward out-of-pocket maximums
Surgery	• 100% Coverage	• 80% Coverage of Reasonable and Customary Charges • Deductible applies • Amounts paid after deductible do apply toward out-of-pocket maximums
Ambulatory Surgery Center Services	• 100% Coverage for physician surgical charges. • $5.00 Copayment per visit for physician office services	• 80% Coverage of Reasonable and Customary Charges • Deductible applies • Amounts paid after deductible do apply toward out-of-pocket maximums
Obstetrical Services (Routine prenatal delivery and postnatal evaluation and management services only)	• $5.00 Copayment per visit up to a maximum Copayment of $60 per pregnancy for routine prenatal and postnatal services only.	• 80% Coverage of Reasonable and Customary Charges • Deductible applies • Amounts paid after deductible do apply toward out-of-pocket maximums
Vasectomy	• 100% Coverage for Physician services when performed in a physician's office or when in connection with other Covered inpatient or outpatient surgery • 100% Coverage for outpatient and inpatient facility charges only when in connection with other Covered inpatient and outpatient surgery	• 80% Coverage for Physician services when performed in a physician's office or when in connection with other Covered inpatient or outpatient surgery • 80% Coverage for outpatient and inpatient facility charges only when in connection with other Covered inpatient and outpatient surgery • Deductible applies • Amounts paid after deductible do apply toward out-of-pocket maximums
Tubal Ligation	• 100% Coverage for Physician services • 100% Coverage for outpatient facility charges • 100% Coverage for inpatient facility charges only when in connection with delivery or other Covered inpatient surgery	• 80% Coverage for Physician services • 80% Coverage for outpatient facility charges • 80% Coverage for inpatient facility charges only when in connection with delivery or other Covered inpatient surgery • Deductible applies • Amounts paid after deductible do apply toward out-of-pocket maximums

Benefits	Network Benefits	Non-Network Benefits
Physician Services (continued)		
Consultations, pre-operative and post-operative visits (Evaluation and management services only)	• $5.00 Copayment may apply	• 80% Coverage of Reasonable and Customary Charges • Deductible applies • Amounts paid after deductible do apply toward out-of-pocket maximums
Allergy Testing	• 100% Coverage	• 80% Coverage of Reasonable and Customary Charges • Deductible applies • Amounts paid after deductible do apply toward out-of-pocket maximums
Allergy Injections	• 100% Coverage	• 80% Coverage of Reasonable and Customary Charges • Deductible applies • Amounts paid after deductible do apply toward out-of-pocket maximums
Family Planning	• 100% Coverage	• 80% Coverage of Reasonable and Customary Charges • Deductible applies • Amounts paid after deductible do apply toward out-of-pocket maximums
Infertility Services (Covered for diagnosis and treatment of underlying cause only)	• 100% Coverage	• 80% Coverage of Reasonable and Customary Charges • Deductible applies • Amounts paid after deductible do apply toward out-of-pocket maximums
Temporomandibular Joint Dysfunction or Syndrome	• 50% Coverage (including physicians' fees and any other related charges) • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits.	• 50% Coverage (including physicians' fees and any other related charges)of Reasonable and Customary Charges • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies
Orthognathic Surgery	• 50% Coverage (including physicians' fees and any other related charges) • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits.	• 50% Coverage (including physicians' fees and any other related charges)of Reasonable and Customary Charges • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies

Benefits	Network Benefits	Non-Network Benefits
Physician Services (continued)		
Certain Surgeries and Treatments (Physician fees only) Reconstructive surgery: blepharoplasty of upper lids, breast reduction, panniculectomy*, rhinoplasty*, septorhinoplasty* and surgical treatment of male gynecomastia **Skin Disorder Treatments**: Scar revision, keloid scar treatment, treatment of hyperhidrosis, excision of lipomas, excision of seborrheic keratoses, excision of skin tags, treatment of vitiligo and port wine stain and hemangioma treatment Varicose veins treatments Sleep apnea treatment procedures*	• Physician fees are Covered at 50%, of the first $2,000.00 for each certain surgery or treatment, 100% thereafter. • Prior approval required for blepharoplasty, breast reduction, panniculectomy, rhinoplasty, septorhinoplasty and sleep apnea treatment. Failure to obtain prior approval will result in a $250.00 reduction in benefits.	• Physician fees are Covered at 50% of the first $2,000.00 of Reasonable and Customary Charges for each certain surgery or treatment, 100% thereafter. • Prior approval required for blepharoplasty, breast reduction, panniculectomy, rhinoplasty, septorhinoplasty and sleep apnea treatment. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies
Treatment of Morbid Obesity • Weight loss programs • Bariatric surgery – limit one per lifetime	• Physician's fees for treatment of morbid obesity is Covered at 50% of the first $2,000.00, 100% thereafter to lifetime maximum benefit of $25,000.00 • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits.	• Physician's fees for treatment of morbid obesity is Covered at 50% of the first $2,000.00 of Reasonable and Customary Charges, 100% thereafter to lifetime maximum benefit of $25,000.00 • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies
HOSPITAL SERVICES (Including radiology examinations and laboratory services)		
Inpatient Hospital Services (Including observation care, transplants and maternity stays for a mother and her Newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section)	• 100% Coverage • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Notification required for admissions following emergency room care	• 80% Coverage of Reasonable and Customary Charges • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Notification required for admissions following emergency room care • Deductible applies • Amounts paid after deductible do apply toward out-of-pocket maximums
Outpatient Hospital Services (Including ambulatory surgery center facility charges)	• 100% Coverage • Some services may require prior approval	• 80% Coverage of Reasonable and Customary Charges • Some services may require prior approval • Deductible applies • Amounts paid after deductible do apply toward out-of-pocket maximums

Benefits	Network Benefits	Non-Network Benefits
Medical Emergency and Urgent Care Services		
Emergency Room Services	• $25.00 Copayment per visit. (Copayment waived only if you become confined as an inpatient in a Hospital.) Emergency Room physician, ancillary and special services are covered in full.	• $25.00 Copayment per visit. (Copayment waived only if you become confined as an inpatient in a Hospital).
Urgent Care Facility Services	• $5.00 Copayment per visit (Copayment applies to all Urgent Care visits)	• 80% Coverage of Reasonable and Customary Charges • Deductible applies • Amounts paid after deductible do apply toward out-of-pocket maximums
Ambulance Services	• $25.00 Copayment	• $25.00 Copayment
Behavioral Health Prior approval by our Behavioral Health Department is required as noted. Call 616 464-8500 or 800 673-8043		
Mental Health and Substance Abuse Inpatient (including partial hospitalization)	• 100% Coverage • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits.	• 80% Coverage of Reasonable and Customary • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies
Mental Health and Substance Abuse Outpatient	• $5.00 Copayment per visit, including med management	• 80% Coverage of Reasonable and Customary Charges per visit • Deductible applies

Benefits	Network Benefits	Non-Network Benefits
OTHER SERVICES		
Radiology Examinations and Laboratory Procedures	• 100% Coverage • High-tech imaging services require prior approval. Failure to obtain prior approval will result in a $250.00 reduction in benefits.	• 80% Coverage of Reasonable and Customary Charges • High-tech imaging services require prior approval. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies • Amounts paid after deductible do apply toward out-of-pocket maximums
Prosthetic and Orthotics/Support Devices	• 100% Coverage • Prior approval required for devices over $1,000.00	• 50% Coverage of Reasonable and Customary Charges • Prior approval required for devices over $1,000.00 • Deductible applies
Durable Medical Equipment (Rent, purchase or repair)	• 100% Coverage • Prior approval required for devices over $1,000.00	• 50% Coverage of Reasonable and Customary Charges • Prior approval required for devices over $1,000.00 • Deductible applies
Facility Services (Non-hospital) • Skilled Nursing • Subacute • Inpatient Rehabilitation • Hospice	• 100% Coverage up to the benefit maximum of 120 days per Contract Year* • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits.	• 80% Coverage of Reasonable and Customary Charges up to the benefit maximum of 120 days per Contract Year* • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies • Amounts paid after deductible do apply toward out-of-pocket maximums
Home Health Care (including Hospice Services, excluding Rehabilitative Medicine) **Note:** Rehabilitative services provided in the home are subject to the limitations of the Rehabilitative Medicine Services benefits described below.	• 100% Coverage • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits.	• 80% Coverage of Reasonable and Customary Charges • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies • Amounts paid after deductible do apply toward out-of-pocket maximums
REHABILITATIVE MEDICINE SERVICES		
Physical and Occupational Therapy (including osteopathic and chiropractic manipulation)	• $5.00 Copayment per visit up to a combined benefit maximum of 40 visits per Contract Year.	• 50% Coverage of reasonable and customary charges up to the combined benefit maximum of 40 visits per Contract Year. • Deductible applies.
Speech Therapy	• $5.00 Copayment per visit up to a combined benefit maximum of 40 visits per Contract Year.	• 50% Coverage of reasonable and customary charges up to the combined benefit maximum of 40 visits per Contract Year. • Deductible applies.
Cardiac Rehabilitation and Pulmonary Rehabilitation	• $5.00 Copayment per visit up to a combined benefit maximum of 40 visits per Contract Year.	• 50% Coverage of reasonable and customary charges up to the combined benefit maximum of 40 visits per Contract Year. • Deductible applies.

Benefits	Network Benefits	Non-Network Benefits
	ADDITIONAL BENEFITS	
Pharmacy Services **Note**: Prescription drug coverage is based on the usage of a medication formulary.	**Tier 1- Generic Drugs** $10 Copay per prescription or refill for a Generic Drug **Tier 2- Preferred Brand-Name Drugs** $20 Copay per prescription or refill for a Preferred Brand-Name Drug **Tier 3- Non-Preferred Brand-Name Drugs** $20 Copay per prescription or refill for a Non-Preferred Brand-Name Drug. Subject to Prior Authorization and/or Step Therapy. **Tier 4- Preferred Specialty Drugs** $20 Copayment for a preferred Specialty Drug. Subject to Prior Authorization and/or Step Therapy. **Tier 5- Non-Preferred Specialty Drugs** $20 Copayment for a non-preferred Specialty Drug. Subject to Prior Authorization and/or Step Therapy. **Infertility Treatment** 50% Copay for drugs used for treating infertility. (Limitations apply) Includes prescription contraceptive drugs and implantable contraceptive drugs. Contraceptive devices administered or supplied in the physician's office are covered at 50%. Does not cover condoms, foams, jellies, ointments and other drugs or devices available over the counter.	• Not Covered
Prescription Mail Order **Filled for up to 90 days**	**Tier 1- Generic Drugs** $20 Copay per prescription or refill for a Generic Drug **Tier 2- Preferred Brand-Name Drugs** $40 Copay per prescription or refill for a Preferred Brand-Name Drug	• Not Covered

	Tier 3- Non-Preferred Brand-Name Drugs $40 Copay per prescription or refill for a Non-Preferred Brand-Name Drug **Tier 4- Preferred Specialty Drugs** Specialty Drugs are limited to a maximum of a 31-day supply per prescription or refill. **Tier 5- Non-Preferred Specialty Drugs** Specialty Drugs are limited to a maximum of a 31-day supply per prescription or refill. Includes prescription contraceptive drugs and implantable contraceptive drugs. (Limitations apply)	
Prescription Drugs for Sexual Dysfunction	Match Rx Copayment for prescription drugs for sexual dysfunction. (Limitations apply)	Not Covered

ELIGIBILITY INFORMATION		
Dependent Children	• Covered until the end of the year in which dependent turns age 19. Additionally covered between the ages of 19 and 25 if dependent is a full-time student, until dependent is no longer a full-time student or reaches the age of 25.	• Covered until the end of the year in which dependent turns age 19. Additionally covered between the ages of 19 and 25 if dependent is a full-time student, until dependent is no longer a full-time student or reaches the age of 25.
Early Retiree Coverage	• Not Available	• Not Available
65+ Retiree Coverage	• Not Available	• Not Available

MAXIMUM LIMITATIONS

A. Benefit Maximums:

* **Benefit Maximums:** Benefit maximums up to a certain number of days/visits/dollar amounts per Contract Year are reached by combining either Network or Non-Network Benefits up to the limit for one or the other, but not both. (Example: If Network Benefits is for 60 visits and Non-Network Benefits is for 60 visits, the maximum benefit is 60 visits, not 120.) Benefit maximums apply even when continued care is Medically/Clinically Necessary beyond the benefit maximum. The Family Out-of-Pocket is not to exceed the Individual Out-of-Pocket maximum per person.

PriorityHealth

Benefit Summary
PriorityHSA℠ - PPO
ROYAL OAK PUBLIC SCHOOLS
Date 12/1/2010 – 11/30/2011
100% Network — 80% Non-Network

The PriorityHSA℠- PPO plan offers you a choice of two benefit levels. The Network Benefits level applies when you use a Network provider. Your out-of-pocket costs are lower when you use this option. The Non-Network level applies when you seek medical services from a Non-Network provider.

The following information is provided as a summary of benefits available under your PriorityHSA℠- PPO plan. This summary is not intended as a substitute for your Policy and Schedule of Benefits. It is not a binding contract. Limitations and exclusions apply to benefits listed below. A complete listing of covered services, limitations and exclusions is contained in the Policy, Schedule of Benefits and any applicable Addenda issued to you. You may request a copy of the Policy from Priority Health's Customer Service Department at 616 464-8830 or 888 389-6645 or on our web site priorityhealth.com. Contact Priority Health's Customer Service Department if you have questions about your benefits or Coverage.

PRIOR APPROVAL

Prior approval is required before you may obtain certain services. If you seek services that require prior approval, without receiving prior approval from us, you will receive a reduction in benefit coverage for those services. You will also be responsible for those services that are beyond those approved, beyond the benefit maximums or excluded from Coverage.

You or your physician must call 800 269-1260 to obtain prior approval for services. Emergency admissions must be notified to us as soon as reasonably possible after admission.

DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS

A. Deductibles:

The Deductible is the amount you must pay first for Covered Services during the Contract Year before benefits will be paid. The Deductible is applicable to all Covered Services received under the Network Benefit level except:

- Routine obstetrical services (deductible will apply to delivery).
- Preventive health services that are listed in Priority Health's Preventive Health Care Guidelines.

The Deductible is combined for Network and Non-Network Benefits. Coverage as detailed in the Benefit Summary will apply after the Deductible is met.

The Deductible is applicable to all Covered Services received under the Non-Network Benefit level or received from Non-Network providers.

If you are the only individual on your contract, you have an Individual Contract and the Individual Contract Deductible applies. If you have more than one individual on your contract, you have a Family Contract and only the Family Contract Deductible applies. The Family Contract Deductible can be satisfied by any one family member or by any combination of family members.

The Combined Network and Non-Network Benefits Deductible renews each Contract Year. This plan does not carry over any Deductible amounts incurred in the prior Contract Year.

The Deductible will include any monies paid for Covered Pharmacy Services.

Notwithstanding the above, the following costs are not credited towards any of the Deductibles: costs for services that exceed the annual day or dollar benefit maximum for a specific benefit (denied as non-Covered Services); penalties for failure to preauthorize services; or, any amounts paid by member for Non-Network Benefits that exceed Reasonable and Customary.

Combined Deductibles	Network & Non-Network Benefits
Individual Contract	$1,500.00
Family Contract	$3,000.00

B. Out-of-Pocket Maximums:

The Out-of-Pocket maximum limits the total amount of covered expenses that you and/or your covered dependents will pay during a Contract Year.

Once the Network Benefits Out-of-Pocket maximum is met, all further Covered medical and pharmacy services incurred at the Network Benefits level will be paid at 100% of Priority Health's contracted rate for the remainder of the Contract Year.

Once the Non-Network Benefits Out-of-Pocket maximum is met, all further Covered medical services incurred at the Non-Network Benefits level will be paid at 100% of the lesser of billed charges or Reasonable and Customary charges for the remainder of the Contract Year.

If you have an Individual Contract, all Copayments, Coinsurance and Deductibles you paid towards Covered Services during the Contract Year will be included when calculating your Out-of-Pocket maximums. If you have a Family Contract, all Copayments, Coinsurance and Deductibles you and/or your covered family members paid collectively towards Covered Services during the Contract Year will be included when calculating your Out-of-Pocket maximums.

Notwithstanding the above, the following costs are not credited towards the Out-of-Pocket maximums: costs for services that exceed the annual day or dollar benefit maximum for a specific benefit (denied as non-Covered Services); penalties for failure to preauthorize services; or, any amounts paid by member for Non-Network Benefits that exceed Reasonable and Customary.

Note that if the non-notification penalty applies, the amount Priority Health pays will be reduced regardless of whether the Out-of-Pocket maximum has been reached.

Out-of-Pocket Maximums	Network Benefits	Non-Network Benefits
Individual Contract	$3,000.00	$4,500.00
Family Contract	$6,000.00	$9,000.00

The amounts calculated towards the Network Benefits Out-of-Pocket Maximums apply to the amounts calculated towards the Non-Network Benefits Out-of-Pocket Maximums. The amounts calculated towards the Non-Network Benefits Out-of-Pocket Maximums apply to the amounts calculated towards the Network Benefits Out-of-Pocket Maximums.

C. Maximum Individual Annual Benefit:

$5,000,000.00 is the combined annual benefit per insured for all Network and Non-Network covered services. (Any reduction in benefits/penalty will apply to the maximum individual annual benefit.)

PriorityHealth

Covered Benefits

Benefits	Network Benefits	Non-Network Benefits
Preventive Health Services	• 100% Coverage • Deductible does not apply	• 80% Coverage of Reasonable and Customary Charges • Deductible applies
PHYSICIAN SERVICES		
Office and Home Visits (evaluation and management services only)	• 100% Coverage • Deductible applies	• 80% Coverage of Reasonable and Customary Charges for face-to-face visits only • Deductible applies
Inpatient Hospital Visits	• 100% Coverage • Deductible applies	• 80% Coverage of Reasonable and Customary Charges • Deductible applies
Surgery	• 100% Coverage • Deductible applies	• 80% Coverage of Reasonable and Customary Charges • Deductible applies
Ambulatory Surgery Center Services	• 100% Coverage for physician surgical charges • Deductible applies	• 80% Coverage of Reasonable and Customary Charges • Deductible applies
Obstetrical Services (Routine prenatal delivery and postnatal evaluation and management services only)	• 100% Coverage for routine prenatal and postnatal services • Deductible does not apply to routine prenatal and postnatal services • Deductible applies to delivery	• 80% Coverage of Reasonable and Customary Charges • Deductible applies
Vasectomy	• 100% Coverage for Physician services when performed in a physician's office or when in connection with other Covered inpatient or outpatient surgery • 100% Coverage for outpatient and inpatient facility charges only when in connection with other Covered inpatient and outpatient surgery • Deductible applies	• 80% Coverage for Physician services when performed in a physician's office or when in connection with other Covered inpatient or outpatient surgery • 80% Coverage for outpatient and inpatient facility charges only when in connection with other Covered inpatient and outpatient surgery • Deductible applies
Tubal Ligation	• 100% Coverage for Physician services • 100% Coverage for outpatient facility charges • 100% Coverage for inpatient facility charges only when in connection with delivery or other Covered inpatient surgery • Deductible applies	• 80% Coverage for Physician services • 80% Coverage for outpatient facility charges • 80% Coverage for inpatient facility charges only when in connection with delivery or other Covered inpatient surgery • Deductible applies

Benefits	Network Benefits	Non-Network Benefits
Physician Services (continued)		
Consultations, pre-operative and post-operative visits (Evaluation and management services only)	• 100% Coverage • Deductible applies	• 80% Coverage of Reasonable and Customary Charges • Deductible applies
Allergy Testing	• 100% Coverage • Deductible applies	• 80% Coverage of Reasonable and Customary Charges • Deductible applies
Allergy Injections	• 100% Coverage • Deductible applies	• 80% Coverage of Reasonable and Customary Charges • Deductible applies
Family Planning	• 100% Coverage • Deductible applies	• 80% Coverage of Reasonable and Customary Charges • Deductible applies
Infertility Services (Covered for diagnosis and treatment of underlying cause only)	• 100% Coverage • Deductible applies	• 80% Coverage of Reasonable and Customary Charges • Deductible applies
Temporomandibular Joint Dysfunction or Syndrome	• 50% Coverage (including physicians' fees and any other related charges) • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies	• 50% Coverage (including physicians' fees and any other related charges)of Reasonable and Customary Charges • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies
Orthognathic Surgery	• 50% Coverage (including physicians' fees and any other related charges) • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies	• 50% Coverage (including physicians' fees and any other related charges)of Reasonable and Customary Charges • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies

Benefits	Network Benefits	Non-Network Benefits
Physician Services (continued)		
Certain Surgeries and Treatments (Physician fees only) Reconstructive surgery: blepharoplasty of upper lids, breast reduction, panniculectomy*, rhinoplasty*, septorhinoplasty* and surgical treatment of male gynecomastia **Skin Disorder Treatments**: Scar revision, keloid scar treatment, treatment of hyperhidrosis, excision of lipomas, excision of seborrheic keratoses, excision of skin tags, treatment of vitiligo and port wine stain and hemangioma treatment Varicose veins treatments Sleep apnea treatment procedures*	• Physician fees are Covered at 50%, of the first $2,000.00 for each certain surgery or treatment, 100% thereafter. • Prior approval required for blepharoplasty, breast reduction, panniculectomy, rhinoplasty, septorhinoplasty and sleep apnea treatment. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies	• Physician fees are Covered at 50% of the first $2,000.00 of Reasonable and Customary Charges for each certain surgery or treatment, 100% thereafter. • Prior approval required for blepharoplasty, breast reduction, panniculectomy, rhinoplasty, septorhinoplasty and sleep apnea treatment. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies
Treatment of Morbid Obesity • Weight loss programs • Bariatric surgery – limit one per lifetime	• Physician's fees for treatment of morbid obesity is Covered at 50% of the first $2,000.00, 100% thereafter to lifetime maximum benefit of $25,000.00 • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies	• Physician's fees for treatment of morbid obesity is Covered at 50% of the first $2,000.00 of Reasonable and Customary Charges, 100% thereafter to lifetime maximum benefit of $25,000.00 • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies
HOSPITAL SERVICES (Including radiology examinations and laboratory services)		
Inpatient Hospital Services (Including observation care, transplants and maternity stays for a mother and her Newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section)	• 100% Coverage • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Notification required for admissions following emergency room care • Deductible applies	• 80% Coverage of Reasonable and Customary Charges • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Notification required for admissions following emergency room care • Deductible applies
Outpatient Hospital Services (Including ambulatory surgery center facility charges)	• 100% Coverage • Some services may require prior approval • Deductible applies	• 80% Coverage of Reasonable and Customary Charges • Some services may require prior approval • Deductible applies

Benefits	Network Benefits	Non-Network Benefits
Medical Emergency and Urgent Care Services		
Emergency Room Services	• 100% Coverage per visit. (Copayment waived only if you become confined as an inpatient in a Hospital.) Emergency Room physician, ancillary and special services are Covered in full. • Deductible applies	• 100% Coverage per visit. (Copayment waived only if you become confined as an inpatient in a Hospital). • Deductible applies
Urgent Care Facility Services	• 100% Coverage per visit (Copayment applies to all Urgent Care visits) • Deductible applies	• 100% Coverage of Reasonable and Customary Charges • Deductible applies
Ambulance Services	• 100% Coverage • Deductible applies	• 100% Coverage • Deductible applies
Behavioral Health Prior approval by our Behavioral Health Department is required as noted. Call 616 464-8500 or 800 673-8043		
Mental Health and Substance Abuse Inpatient **(including partial hospitalization)**	• 100% Coverage • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies	• 80% Coverage of Reasonable and Customary Charges • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies
Mental Health and Substance Abuse Outpatient	• 100% Coverage per visit, including med management • Deductible applies	• 80% Coverage of Reasonable and Customary Charges per visit • Deductible applies

Benefits	Network Benefits	Non-Network Benefits
OTHER SERVICES		
Radiology Examinations and Laboratory Procedures	• 100% Coverage • High-tech imaging services require prior approval. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies	• 80% Coverage of Reasonable and Customary Charges • High-tech imaging services require prior approval. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies
Prosthetic and Orthotics/Support Devices	• 90% Coverage • Prior approval required for devices over $1,000.00 • Deductible applies	• 50% Coverage of Reasonable and Customary Charges • Prior approval required for devices over $1,000.00 • Deductible applies
Durable Medical Equipment (Rent, purchase or repair)	• 90% Coverage • Prior approval required for devices over $1,000.00 • Deductible applies	• 50% Coverage of Reasonable and Customary Charges • Prior approval required for devices over $1,000.00 • Deductible applies
Facility Services (Non-hospital) • Skilled Nursing • Subacute • Inpatient Rehabilitation • Hospice	• 100% Coverage up to the benefit maximum of 45 days per Contract Year* • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies	• 80% Coverage of Reasonable and Customary Charges up to the benefit maximum of 45 days per Contract Year* • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies
Home Health Care (including Hospice Services, excluding Rehabilitative Medicine) **Note:** Rehabilitative services provided in the home are subject to the limitations of the Rehabilitative Medicine Services benefits described below.	• 100% Coverage • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies	• 80% Coverage of Reasonable and Customary Charges • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies
Advanced Diagnostic Imaging Includes, but is not limited to the following: CT, CTA, MRI, MRA, Nuclear Cardiology Studies and PET scanning. Prior Approval is required for certain radiology examinations.	• 100% coverage per test after deductible. (Copayment waived if performed while confined as an inpatient in a Hospital.)	• 80% coverage per test after deductible. (Copayment waived if performed while confined as an inpatient in a Hospital.)
REHABILITATIVE MEDICINE SERVICES		
Physical and Occupational Therapy (including osteopathic and chiropractic manipulation)	• 100% Coverage per visit up to a combined benefit maximum of 50 visits per Contract Year. • Deductible applies	• 50% Coverage of reasonable and customary charges up to the combined benefit maximum of 50 visits per Contract Year. • Deductible applies
Speech Therapy	• 100% Coverage per visit up to a combined benefit maximum of 50 visits per Contract Year. • Deductible applies	• 50% Coverage of reasonable and customary charges up to the combined benefit maximum of 50 visits per Contract Year. • Deductible applies

Cardiac Rehabilitation and Pulmonary Rehabilitation	• 100% Coverage per visit up to a combined benefit maximum of 50 visits per Contract Year. • Deductible applies	• 50% Coverage of reasonable and customary charges up to the combined benefit maximum of 50 visits per Contract Year. • Deductible applies

Benefits	Network Benefits	Non-Network Benefits
	ADDITIONAL BENEFITS	
Prescription Drugs **Note:** Prescription drug coverage is based on the usage of a medication formulary. Deductible applies.	**Tier 1- Generic Drugs** 100% Coverage per prescription or refill for a Generic Drug **Tier 2- Preferred Brand-Name Drugs** 100% Coverage per prescription or refill for a Preferred Brand-Name Drug **Tier 3- Non-Preferred Brand-Name Drugs** 100% Coverage per prescription or refill for a Non-Preferred Brand-Name Drug. Subject to Prior Authorization and/or Step Therapy. **Tier 4- Preferred Specialty Drugs** 100% Coverage for a preferred Specialty Drug. Subject to Prior Authorization and/or Step Therapy. **Tier 5- Non-Preferred Specialty Drugs** 100% Coverage for a non-preferred Specialty Drug. Subject to Prior Authorization and/or Step Therapy. **Infertility Treatment** 50% Copay for drugs used for treating infertility. (Limitations apply) Includes prescription contraceptive drugs and implantable contraceptive drugs. *Contraceptive devices administered or supplied in the physician's office are covered at 50%. Does not cover condoms, foams, jellies, ointments and other drugs or devices available over the counter.*	Not Covered

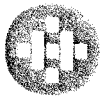
Prescription Mail Order Filled for up to 90 days Deductible Applies.	**Tier 1- Generic Drugs** 100% Coverage per prescription or refill for a Generic Drug **Tier 2- Preferred Brand-Name Drugs** 100% Coverage per prescription or refill for a Preferred Brand-Name Drug **Tier 3- Non-Preferred Brand-Name Drugs** 100% Coverage per prescription or refill for a Non-Preferred Brand-Name Drug **Tier 4- Preferred Specialty Drugs** Specialty Drugs are limited to a maximum of a 31-day supply per prescription or refill. **Tier 5- Non-Preferred Specialty Drugs** Specialty Drugs are limited to a maximum of a 31-day supply per prescription or refill. Includes prescription contraceptive drugs and implantable contraceptive drugs. (Limitations apply)	Not Covered

ELIGIBILITY INFORMATION		
Dependent Children	• Covered until the end of the year in which dependent turns age 19. Additionally covered between the ages of 19 and 25 if dependent is a full-time student, until dependent is no longer a full-time student or reaches the age of 25.	• Covered until the end of the year in which dependent turns age 19. Additionally covered between the ages of 19 and 25 if dependent is a full-time student, until dependent is no longer a full-time student or reaches the age of 25.
Early Retiree Coverage	Not Available	Not Available
65+ Retiree Coverage	Not Available	Not Available

MAXIMUM LIMITATIONS

A. Benefit Maximums:

* **Benefit Maximums:** Benefit maximums up to a certain number of days/visits/dollar amounts per Contract Year are reached by combining either Network or Non-Network Benefits up to the limit for one or the other, but not both. (Example: If Network Benefits is for 60 visits and Non-Network Benefits is for 60 visits, the maximum benefit is 60 visits, not 120.) Benefit maximums apply even when continued care is Medically/Clinically Necessary beyond the benefit maximum. The Family Out-of-Pocket is not to exceed the Individual Out-of-Pocket maximum per person.



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The attached Benefit Summary does **not** reflect updated language required by the **Patient Protection and Affordable Care Act (PPACA)** and its subsequent regulations.

Priority Health is in the process of updating materials to include information that is required as of 9/23/2010. As soon as this information is available, a revised Benefit Summary will be provided.

Dental

SET SEG

Dental Plan Comparison

Royal Oak Public Schools
Teachers

DISCLAIMER: This document is a summary of certain plan features. It should not be interpreted as a complete comparison of the products represented.

	CURRENT PLAN		CURRENT PLAN					
Name	**Teachers with Medical**		**Teachers without Medical**		**SET UD 100/85/70/50; $1,000/$1,500**		**SET SF 100/85/70/50; $1,000/$1,500**	
Carrier	**MESSA**		**MESSA**		**SET**		**SET TPA**	
Rate Expiration	6/30/2011		6/30/2011		6/30/2011		6/30/2011	
Purchased Plan Features	**In Network**		**In Network**		**In Network**		**In Network**	
Prevent %	100%		100%		100%		100%	
Basic %	85%		85%		85%		85%	
Major %	70%		70%		70%		70%	
Ortho %	50%		50%		50%		50%	
Basic Ded	$0		$0		$0		$0	
Major Ded	$0		$0		$0		$0	
Ortho Ded	$0		$0		$0		$0	
Bas/Maj Max	$1,000		$1,000		$1,000		$1,000	
Ortho Max	$1,500		$1,500		$1,500		$1,500	
Sealants Covered	No		No		No		No	
Implants Covered	Yes		Yes		Yes		Yes	
Purchased Plan Rates	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**
One Person (1P)	43	$105.15	2	$109.33	45	$32.89	45	$93.99
Two Person (2P)	51	$105.15	6	$109.33	57	$109.89	57	$93.99
Family (FF)	149	$105.15	15	$109.33	164	$109.89	164	$93.99
Projected Increase (0%)	0%		0%					
Total Annual Premium	**243**	**$306,617**	**23**	**$30,175**	**266**	**$309,189**	**266**	**$300,016**
Combined Annual Premium	**$336,792**		**< TOTALS**					
Estimated Savings - $					**$9**	**$27,604**	**$12**	**$36,776**
Estimated Savings - %						**8%**		**11%**

SET SEG

Dental Plan Summary

Royal Oak Public Schools

Teachers

Assumed Effective Date: 12/1/2010

Current Plan(s) and Segment:		1P	2P	FF	Monthly Composite	Total Annual Cost	Rate Expiration
Teachers with Medical	Census	43	51	149	$105.15	$306,617	6/30/2011
MESSA 100/85/70/50/1000/1500	Rate	$105.15	$105.15	$105.15			
Teachers without Medical	Census	2	6	15	$109.33	$30,175	6/30/2011
MESSA 100/85/70/50/1000/1500	Rate	$109.33	$109.33	$109.33			
	TOTALS:	**45**	**57**	**164**		**$336,792**	

Product Name	Quote Expires	1P Rate	2P Rate	FF Rate	Monthly Composite	Total Cost	Estimated Annual Savings
SET UD 100/85/70/50; $1,000/$1,500	6/30/2011	$32.89	$109.89	$109.89	$96.86	$309,189	$27,604
SET SF 100/85/70/50; $1,000/$1,500	6/30/2011	$93.99	$93.99	$93.99	$93.99	$300,016	$36,776
BCBSM Plan 3: 100/75/50/50; 1,000/1,000 Max	6/30/2011	$63.41	$152.17	$190.22	$160.61	$512,679	-$175,886
MESSA 100/85/70/50; $1,000/$1,500	Declined						
Guardian 100/85/70/50; $1,000/$1,500	No Bid						
Sun Life 100/85/70/50; $1,000/$1,500	6/30/2011	$44.03	$88.44	$155.27	$122.13	$389,841	-$53,048

SET SF plan matches current level of benefits and members may visit doctor of choice

SET SEG

Dental Plan Comparison

Royal Oak Public Schools
Secretaries

DISCLAIMER: This document is a summary of certain plan features. It should not be interpreted as a complete comparison of the products represented.

	CURRENT PLAN		CURRENT PLAN			
Name	**Secretaries with Medical**		**Secretaries wtihout Medical**		**SET SF 100/50/50/50; $1,000/$1,000**	
Carrier	**MESSA**		**MESSA**		**SET TPA**	
Rate Expiration	6/30/2011		6/30/2011		6/30/2011	
Purchased Plan Features	**In Network**		**In Network**		**In Network**	
Prevent %	100%		100%		100%	
Basic %	50%		50%		50%	
Major %	50%		50%		50%	
Ortho %	50%		50%		50%	
Basic Ded	$0		$0		$0	
Major Ded	$0		$0		$0	
Ortho Ded	$0		$0		$0	
Bas/Maj Max	$1,000		$1,000		$1,000	
Ortho Max	$1,000		$1,000		$1,000	
Sealants Covered	No		No		No	
Implants Covered	Yes		Yes		Yes	
Purchased Plan Rates	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**
One Person (1P)	7	$64.30	0	$74.10	7	$59.54
Two Person (2P)	35	$64.30	5	$74.10	40	$59.54
Family (FF)	18	$64.30	3	$74.10	21	$59.54
Projected Increase (0%)	0%		0%			
Total Annual Premium	**60**	**$46,296**	**8**	**$7,114**	**68**	**$48,585**
Combined Annual Premium	**$53,410**		**< TOTALS**			
Estimated Savings - $					**$6**	**$4,825**
Estimated Savings - %						**9%**

SET SEG

Dental Plan Summary

Royal Oak Public Schools

Secretaries

Assumed Effective Date: 12/1/2010

Current Plan(s) and Segment:		1P	2P	FF	Monthly Composite	Total Annual Cost	Rate Expiration
Secretaries with Medical	Census	7	35	18	$64.30	$46,296	6/30/2011
MESSA 100/50/50/50/1000/1000	Rate	$64.30	$64.30	$64.30			
Secretaries wtihout Medical	Census		5	3	$74.10	$7,114	6/30/2011
MESSA 100/50/50/50/1000/1000	Rate	$74.10	$74.10	$74.10			
	TOTALS:	**7**	**40**	**21**		**$53,410**	

Product Name	Quote Expires	1P Rate	2P Rate	FF Rate	Monthly Composite	Total Cost	Estimated Annual Savings
SET UD 100/50/50/50; $1,000/$1,000	6/30/2011	$23.66	$81.03	$81.03	$75.12	$61,301	-$7,892
SET SF 100/50/50/50; $1,000/$1,000	6/30/2011	$59.54	$59.54	$59.54	$59.54	$48,585	$4,825
BCBSM Plan 3: 100/75/50/50; 1,000/1,000 Max	6/30/2011	$43.47	$104.33	$130.41	$106.12	$86,593	-$33,184
BCBSM Plan 7: 100/75/50/50; 1,500/1,500 Max	6/30/2011	$47.71	$114.49	$143.13	$116.46	$95,032	-$41,622
MESSA 100/50/50/50; $1,000/$1,000	Declined						
Guardian 100/50/50/50; $1,000/$1,000	No Bid						
Sun Life 100/50/50/50; $1,000/$1,000	6/30/2011	$28.84	$58.81	$107.85	$70.87	$57,830	-$4,420

SET SF plan matches current level of benefits and members may visit doctor of choice

SET SEG

Dental Plan Summary

Royal Oak Public Schools
Psychologists, Administrators, and Non-Affiliated
Assumed Effective Date: 12/1/2010

Current Plan(s) and Segment:		1P	2P	FF	Monthly Composite	Total Annual Cost	Rate Expiration
Psychologists, Administrators and Non-Affiliated	Census	5	12	18	$79.34	$33,323	6/30/2011
SET SEG SF 100/85/60/50/1000/1500	Rate	$79.34	$79.34	$79.34			
	TOTALS:	**5**	**12**	**18**		**$33,323**	

Product Name	Quote Expires	1P Rate	2P Rate	FF Rate	Monthly Composite	Total Cost	Estimated Annual Savings
SET UD 100/85/60/50; $1,000/$1,500	6/30/2011	$31.76	$107.70	$107.70	$96.85	$40,678	-$7,355
BCBSM Plan 3: 100/75/50/50; 1,000/1,000 Max	6/30/2011	$41.96	$100.69	$125.88	$105.25	$44,207	-$10,884
BCBSM Plan 7: 100/75/50/50; 1,500/1,500 Max	6/30/2011	$45.44	$109.07	$136.32	$113.99	$47,878	-$14,555
MESSA 100/85/60/50; $1,000/$1,500	Declined						
Guardian 100/85/60/50; $1,000/$1,500	No Bid						
Sun Life 100/85/60/50; $1,000/$1,500	6/30/2011	$50.70	$102.67	$184.57	$137.37	$57,694	-$24,371

SET SF plan matches current level of benefits and members may visit doctor of choice

Dental Plan Disclaimers:

Please take note of the following disclaimers if you are interested in a dental plan shown within this proposal.

SET SEG Insured:

Plans quoted may include the unique SET incentive benefit. Please refer to the plan summary page for details.

Insured plans include access to the Dentemax dental network. Dentists in this network provide discounted services and agree to accept Dentemax prices as full payment of services. You can find Dentemax dentists at www.denemaxdental.com. Your benefit level will remain the same regardless of whether you are in or out of network.

The material presented is a matter of general information. The certificate or policy issued at point of sale is the controlling document.

SET SEG Self-Funded:

Benefit year follows a calendar year.

SET Self-Funded dental options are presented with illustrative rates and will be based on actual claims data provided by the district. If claims data is not provided, SET will estimate a self-funded rate based on the cost of an insured product with matching benefit levels.

SET Self-Funded plans match current level of benefits unless otherwise requested. Members may visit doctor of choice.

Blue Cross Blue Shield of Michigan:

Presentation materials found within this proposal are not considered contractual information. Additional limitations and exclusions may apply to covered services. For an official description of benefits, please see the applicable BCBSM certificate and riders.

SET SEG
School Insurance Specialists

Self-Funded Dental Savings Projection

Royal Oak Public Schools

Estimated Costs and Savings:

Self-funded savings considerations:
- Plan includes coordination of benefits (COB)
- Complete claims reports are provided

Fully Insured Costs:

Segment			Teachers		Secretaries
Number of Insureds			266		68
Approximate Monthly Premium per Employee (Insured)		$	106	$	65
Approximate Annual Premium per Employee (Insured)		$	1,267	$	786
Approximate Total Monthly District Premium Expense		$	28,066	$	4,451
Approximate Total Annual District Premium Expense		$	336,788	$	53,407
Self-Funded Costs:					
Set-Up Fee (one-time)		$	350	$	200
Monthly Administrative Fee	$3.25 /month	$	865	$	221
Annual Administrative Fee		$	10,374	$	2,652
Claims Fund:					
Two Months of Estimated Premium		$	57,000	$	9,000
Loss Ratio: (based on actual claims)			86%		86%
Analysis:					
Estimated Claims (annual premium x loss ratio)		$	289,638	$	45,931
Administrative Fees		$	10,374	$	2,652
Set-Up Fee (one-time)		$	350	$	200
Total Estimated Self-Funded Costs (claims + fees)		$	300,012	$	48,583
Fully Insured Costs (annual)		$	336,788	$	53,407
Estimated Savings		**$**	**36,776**	**$**	**4,824**
Self-Funded Composite Rate			**93.99**		**59.54**

SET SEG
School Insurance Specialists

SET Self-Funded Dental Proposal
Royal Oak Public Schools

BENEFIT YEAR

- Dental: January 1 through December 31

CLAIM FUND

- The claim fund will be in the amount equal to two months of actual claims or two months of the current insured premium.
- Subsequent months will be the amount actually paid in claims the prior month.
- District will be invoiced by the 5th of each month.
- District will remit payment by the 20th of the month.

Segment	Setup Fee
Teachers	$ 350
Secretaries	$ 200
*Setup fee is based on total number of subscribers.	

CLAIM REPORTS

- SET SEG will provide monthly reports

MISCELLANEOUS:

- Customized benefit brochures will be provided at no cost to the district.
- Please note that a 30-day lead-time is required to effectuate benefits.

*Monthly administration fee is $3.25. If a Self-Funded Vision plan is also purchased, the Dental fee will be reduced to $3.00.

ADVANTAGES WITH SET

- ✓ **Guaranteed accurate administration of contract.**
- ✓ **Coordination of Benefits (C.O.B.)**
- ✓ **Availability of passive SET Dental Network (ADN network) for additional fee ($1.50 per employee/per month or 12% of re-priced claims)**
- ✓ **Plan design flexibility**
- ✓ **Opportunity for lower cost**
- ✓ **Continuation of current benefit levels**

Benefit Summaries

SET SEG
School Insurance Specialists

Ultra-Dent Fully Funded Plan
Benefits-at-a-Glance

Royal Oak Public Schools
Teachers

Basic Benefits	In-Network	Out-of-Network
Examination – includes initial and periodic 2 per member per benefit year[1]	Covered - 100% DenteMax price*	Covered - 100% R&C*
Cleaning – adult, and child 2 per member per benefit year[1]	Covered - 100% DenteMax price*	Covered - 100% R&C*
Fluoride – to age 18 2 per member per benefit year[1]	Covered - 100% DenteMax price*	Covered - 100% R&C*
Restorative-Fillings	85% DenteMax price*	85% R&C*
Oral Surgery	85% DenteMax price*	85% R&C*
Endodontics	85% DenteMax price*	85% R&C*
Periodontics	85% DenteMax price*	85% R&C*
Lifetime Deductible	$0	$0

Major Benefits		
Inlays, Onlays, Crowns, Post/Cores and Repairs	70% DenteMax price*	70% R&C*
Bridges and Repairs	70% DenteMax price*	70% R&C*
Dentures	70% DenteMax price*	70% R&C*
Annual Deductible	$0	$0

Annual Maximum
$1,000 per person per benefit year[1] for basic and major services combined.

Orthodontic Services		
Payment @	50% DenteMax price*	50% R&C*
Annual Deductible	$0	$0
Lifetime maximum	$1,500	$1,500
☒ To Age 19		
☐ Adult Orthodontic coverage – no age limit		

[1] Benefit year for this plan is January 1 through December 31.

* The plan will pay the DenteMax approved amount to the dentist for the eligible services. You are responsible for the co-payment and/or deductible amount as identified in the benefit summary.

* The plan will pay the Reasonable and Customary (R&C) amount to the dentist for the eligible services. You are responsible for the co-payment and/or deductible amount as identified in the benefit summary. Any remaining balance in excess of the R& C amount is your responsibility.

Your Plan Includes: Options A, B, F and T

Option A	**Covers bridge and/or denture work for new or existing insured if the missing teeth were extracted prior to the effective date of the service contract (only exception is congenitally missing teeth)**
Option B	**Waives the five-year replacement limitation on bridge, crown or denture work**
Option F	**Covers orthodontia started prior to the effective contract date**
Option T	**Implants**

Fully Insured Monthly Rates until July 1, 2011
Note: The material is presented as a matter of general information. The policy issued by Union Security Insurance Company to SET, Inc. is the controlling document.

Note: Your plan includes access to the DENTEMAX dental network. Dentists in this network provide discounted services and agree to accept DENTEMAX prices as full payment for services. You can find DENTEMAX dentists at www.dentemaxdental.com. Your benefit levels are the same regardless of whether you are in or out of network.

Why Use DenteMax?

DenteMax is Committed to Building a Best-in-Class National Dental Network

ACCESS to one of the BEST dental networks in the country

- Over 65,000 credentialed dentist access points.
- Adding hundreds of new dentists each month.

QUALITY dentists

- Every DenteMax dentist undergoes a credentialing process before they can join the network.
- DenteMax takes pride in offering the highest quality of dental care; you will be treated by the best of the best.

SAVINGS every time you go to a network dentist

- Reduce out of pocket costs.
- Stretch annual maximum benefits.

Typical Charge	**$800.00**	**DenteMax Charge**	**$600.00**
Coinsurance	**50%**	**Coinsurance**	**50%**
Plan Benefit Pays	**$400.00**	**Plan Benefit Pays**	**$300.00**
You Pay	**$400.00**	**You Pay**	**$300.00**

YOU SAVE $100.00 WITH DENTEMAX

DENTEMAX
COMMITTED TO EXCELLENCE
SINCE 1985

Frequently Asked Questions about DenteMax

Q. What is DenteMax?

DenteMax is a national, dental Preferred Provider Organization (PPO) network. This means that you can visit any participating dentist in the list of DenteMax dentists and save on your dental costs. DenteMax is a group of quality dentists who have agreed to accept a set, discounted fee schedule when they see DenteMax patients.

Q. Why should I go to a DenteMax dentist?

When you choose a DenteMax dentist, you can save on out-of-pocket expenses. DenteMax fees are generally less than a dentist's usual office fees.
DenteMax credentials all dentists before allowing them to join. DenteMax checks into a dentist's current practice information and history to make sure that all DenteMax dentists are the highest quality. This gives you peace of mind knowing that you are seeing a quality checked DenteMax dentist.

Q. How do I find a DenteMax dentist?

You can go online to *www.dentemax.com* at your convenience to find the most up to date list of DenteMax dentists. You can call us toll-free at 1-800-752-1547 and a live representative will help you locate an in-network provider in your area. You can also use our directories to find a DenteMax dentist.

Q. Is DenteMax my Insurance Company?

DenteMax is solely a network of dentists, not an insurance company. DenteMax is a preferred provider network of dentists who have accepted a set fee schedule when receiving payment for dental services.

Q. How do I find out what dental services are covered?

Since DenteMax is solely a dental network, we do not have information on your benefit levels or what services are covered. You must call your Health Benefit Plan at the number on your ID card for information on your benefit levels and eligibility.

Q. If my dentist is not yet participating with DenteMax, how can he/she join?

Contact your dentist and advise him/her that you now have DenteMax. Ask if he/she would be willing to join. If they are willing and would like to review our information, simply have your dentist or yourself call us at 1-800-752-1547. You can also refer your dentist to DenteMax directly by phone or by website at www.dentemax.com. We will be glad to contact the dental office with information on joining our program.

SET SEG
School Insurance Specialists

Self-Funded Dental Plan
Benefits-at-a-Glance

Royal Oak Public Schools
Teachers

Basic Benefits

Examination☑ – includes initial and periodic	Covered - 100% R&C✱, 2 per member per benefit year[1]
Cleaning☑ – adult, and child	Covered - 100% R&C✱, 2 per member per benefit year[1]
Fluoride☑ – to age 18	Covered - 100% R&C✱, 2 per member per benefit year[1]
Restorative-Fillings☑	85% R&C✱
Oral Surgery☑	85% R&C✱
Endodontics☑	85% R&C✱
Periodontics☑	85% R&C✱
Lifetime Deductible	$0

Major Benefits

Inlays, Onlays, Crowns, Post/Cores and Repairs	70% R&C✱
Bridges and Repairs	70% R&C✱
Dentures	70% R&C✱
Annual Deductible	$0

Annual Maximum

$1,000 per person per benefit year for basic and major services combined.

Orthodontic Services

Payment @	50% R&C✱
Lifetime maximum	$1,500
☒ To Age 19	
☐ Adult Orthodontic coverage – no age limit	

[1] Benefit year for this plan is January 1 through December 31.

✱ The plan will pay the Reasonable and Customary (R&C) amount to the dentist for the eligible services. You are responsible for the co-payment and/or deductible amount as identified in the benefit summary. Any remaining balance in excess of the R&C amount is your responsibility.

Your Plan Includes: Options A, B, F and T

Option A	**Covers bridge and/or denture work for new or existing insured if the missing teeth were extracted prior to the effective date of the service contract (only exception is congenitally missing teeth)**
Option B	**Waives the five-year replacement limitation on bridge, crown or denture work**
Option F	**Covers orthodontia started prior to the effective contract date**
Option T	**Implants**

SET SEG
School Insurance Specialists

Self-Funded Dental Plan
Benefits-at-a-Glance

Royal Oak Public Schools
Secretaries

Basic Benefits

Examination☑ – includes initial and periodic	Covered - 100% R&C✱, 2 per member per benefit year[@]
Cleaning☑ – adult, and child	Covered - 100% R&C✱, 2 per member per benefit year[@]
Fluoride☑ – to age 18	Covered - 100% R&C✱, 2 per member per benefit year[@]
Restorative-Fillings☑	50% R&C✱
Oral Surgery☑	50% R&C✱
Endodontics☑	50% R&C✱
Periodontics☑	50% R&C✱
Lifetime Deductible	$0

Major Benefits

Inlays, Onlays, Crowns, Post/Cores and Repairs	50% R&C✱
Bridges and Repairs	50% R&C✱
Dentures	50% R&C✱
Annual Deductible	$0

Annual Maximum

$1,000 per person per benefit year for basic and major services combined.

Orthodontic Services

Payment @	50% R&C✱
Lifetime maximum	$1,000
☒ To Age 19	
☐ Adult Orthodontic coverage – no age limit	

[@] Benefit year for this plan is January 1 through December 31.

✱ The plan will pay the Reasonable and Customary (R&C) amount to the dentist for the eligible services. You are responsible for the co-payment and/or deductible amount as identified in the benefit summary. Any remaining balance in excess of the R&C amount is your responsibility.

Your Plan Includes: Options A, B, F and T

Option A	**Covers bridge and/or denture work for new or existing insured if the missing teeth were extracted prior to the effective date of the service contract (only exception is congenitally missing teeth)**
Option B	**Waives the five-year replacement limitation on bridge, crown or denture work**
Option F	**Covers orthodontia started prior to the effective contract date**
Option T	**Implants**

Vision

SET SEG

Vision Plan Comparison

Royal Oak Public Schools
Teachers

DISCLAIMER: This document is a summary of certain plan features. It should not be interpreted as a complete comparison of the products represented.

	CURRENT PLAN		CURRENT PLAN		CURRENT PLAN							
Name	**Teachers Pak A**		**Teachers Pak C**		**Teachers Pak B**		**SET Vision Self-funded Plan 3 - $65 Frames**		**UHCV Platinum**		**NVA VSP Plan 3 Match**	
Carrier	**MESSA VSP Plan 3**		**MESSA VSP Plan 3**		**MESSA VSP Plan 3**		**SET TPA**		**United Healthcare Vision**		**NVA**	
Rate Period	7/1/2010 - 6/30/2011		7/1/2010 - 6/30/2011		7/1/2010 - 6/30/2011		12/1/2010 - 6/30/2011		12/1/2010 - 6/30/2011		12/1/2010 - 6/30/2014	
Purchased Plan Features	**In Network**	**Out of Network Allowance**	**In Network**	**Out of Network Allowance**	**In Network**	**Out of Network Allowance**	**In Network**	**Out of Network Allowance**	**In Network**	**Out of Network Allowance**	**In Network**	**Out of Network Allowance**
Optometrist Exam	100%	$35	100%	$35	100%	$35	$64	$64	100%	$45	100%	$35
Ophthalmologist Exam	100%	$45	100%	$45	100%	$45	$64	$64	100%	$45	100%	$45
Regular Lenses	100%	$38	100%	$38	100%	$38	$84	$84	100%	$56	100%	$38
Bifocal Lenses	100%	$60	100%	$60	100%	$60	$96	$96	100%	$90	100%	$60
Trifocal Lenses	100%	$72	100%	$72	100%	$72	$120	$120	100%	$110	100%	$72
Lentiuclar Lenses	100%	$108	100%	$108	100%	$108	$144	$144	100%	$138	100%	$108
Frames	$65	$55	$65	$55	$65	$55	$65	$65	$130	$66	$65	$55
Necessary Contacts	$115	$115	$115	$115	$115	$115	$200	$200	100%	$200	$115	$115
Cosmetic Contacts	$115	$115	$115	$115	$115	$115	$200	$200	$200	$200	$115	$115
Exam Copay	$0.00	n/a	$0.00	n/a	$0.00	n/a	$0.00	n/a	$0.00	n/a	$0.00	n/a
Material Copay	$0.00	n/a	$0.00	n/a	$0.00	n/a	$0.00	n/a	$0.00	n/a	$0.00	n/a
Purchased Plan Rates	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**
One Person (1P)	7	$17.44	36	$18.60	2	$20.18	45	$15.48	45	$16.95	45	$5.04
Two Person (2P)	6	$17.44	45	$18.60	6	$20.18	57	$15.48	57	$16.95	57	$9.34
Family (FF)	10	$17.44	139	$18.60	15	$20.18	164	$15.48	164	$16.95	164	$13.36
Projected Increase (0%)	0%		0%		0%							
Total Annual Premium	**23**	**$4,813**	**220**	**$49,104**	**23**	**$5,570**	**266**	**$49,412**	**266**	**$54,104**	**266**	**$35,403**
Combined Annual Premium	**$59,487**		**< TOTALS**		**< TOTALS**							
Estimated Savings - $							**$3**	**$10,075**	**$2**	**$5,383**	**$8**	**$24,084**
Estimated Savings - %								**17%**		**9%**		**40%**
Quote Expiration							6/30/2011		6/30/2011		6/30/2014	

SET SEG

Vision Plan Summary

Royal Oak Public Schools

Teachers

Assumed Effective Date: 12/1/2010

Current Plan(s) and Segment:			1P	2P	FF	Monthly Composite	Total Annual Cost	Rate Period
Teachers Pak A		Census	7	6	10	$17.44	$4,813	7/1/2010 - 6/30/2011
	MESSA VSP Plan 3	Rate	$17.44	$17.44	$17.44			
Teachers Pak C		Census	36	45	139	$18.60	$49,104	7/1/2010 - 6/30/2011
	MESSA VSP Plan 3	Rate	$18.60	$18.60	$18.60			
Teachers Pak B		Census	2	6	15	$20.18	$5,570	7/1/2010 - 6/30/2011
	MESSA VSP Plan 3	Rate	$20.18	$20.18	$20.18			
		TOTALS:	**45**	**57**	**164**		**$59,487**	

Product Name	1P	2P	FF	Monthly Composite	Total Annual Cost	Estimated Annual Savings
SET UltraVision Plan 3 - $65 Frames	$12.54	$34.45	$34.45	$30.75	$98,140	-$38,653
SET Vision Self-funded Plan 3 - $65 Frames	$15.48	$15.48	$15.48	$15.48	$49,412	$10,075
UHCV Platinum	$16.95	$16.95	$16.95	$16.95	$54,104	$5,383
NVA VSP Plan 3 Match	$5.04	$9.34	$13.36	$11.09	$35,403	$24,084
MESSA VSP Plan 3	Declined					

SET SEG

Vision Plan Comparison

Royal Oak Public Schools
Secretaries

DISCLAIMER: This document is a summary of certain plan features. It should not be interpreted as a complete comparison of the products represented.

	CURRENT PLAN		CURRENT PLAN		CURRENT PLAN							
Name	**Secretaries Pak A**		**Secretaries Pak C**		**Secretaries Pak B**		**SET Vision Self-funded Plan 3 - $65 Frames**		**UHCV Platinum**		**NVA VSP Plan 3 Match**	
Carrier	**MESSA VSP Plan 3**		**MESSA VSP Plan 3**		**MESSA VSP Plan 3**		**SET TPA**		**United Healthcare Vision**		**NVA**	
Rate Period	7/1/2010 - 6/30/2011		7/1/2010 - 6/30/2011		7/1/2010 - 6/30/2011		12/1/2010 - 6/30/2011		12/1/2010 - 6/30/2011		12/1/2010 - 6/30/2014	
Purchased Plan Features	**In Network**	**Out of Network Allowance**	**In Network**	**Out of Network Allowance**	**In Network**	**Out of Network Allowance**	**In Network**	**Out of Network Allowance**	**In Network**	**Out of Network Allowance**	**In Network**	**Out of Network Allowance**
Optometrist Exam	100%	$35	100%	$35	100%	$35	$64	$64	100%	$45	100%	$35
Ophthalmologist Exam	100%	$45	100%	$45	100%	$45	$64	$64	100%	$45	100%	$45
Regular Lenses	100%	$38	100%	$38	100%	$38	$84	$84	100%	$56	100%	$38
Bifocal Lenses	100%	$60	100%	$60	100%	$60	$96	$96	100%	$90	100%	$60
Trifocal Lenses	100%	$72	100%	$72	100%	$72	$120	$120	100%	$110	100%	$72
Lentiuclar Lenses	100%	$108	100%	$108	100%	$108	$144	$144	100%	$138	100%	$108
Frames	$65	$55	$65	$55	$65	$55	$65	$65	$130	$66	$65	$55
Necessary Contacts	$115	$115	$115	$115	$115	$115	$200	$200	100%	$200	$115	$115
Cosmetic Contacts	$115	$115	$115	$115	$115	$115	$200	$200	$200	$200	$115	$115
Exam Copay	$0.00	n/a	$0.00	n/a	$0.00	n/a	$0.00	n/a	$0.00	n/a	$0.00	n/a
Material Copay	$0.00	n/a	$0.00	n/a	$0.00	n/a	$0.00	n/a	$0.00	n/a	$0.00	n/a
Purchased Plan Rates	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**
One Person (1P)	0	$21.21	7	$18.85	0	$21.21	7	$15.95	7	$16.95	7	$5.04
Two Person (2P)	0	$21.21	35	$18.85	5	$21.21	40	$15.95	40	$16.95	40	$9.34
Family (FF)	4	$21.21	14	$18.85	3	$21.21	21	$15.95	21	$16.95	21	$13.36
Projected Increase (0%)	0%		0%		0%							
Total Annual Premium	**4**	**$1,018**	**56**	**$12,667**	**8**	**$2,036**	**68**	**$13,015**	**68**	**$13,831**	**68**	**$8,273**
Combined Annual Premium	**$15,721**		**< TOTALS**		**< TOTALS**							
Estimated Savings - $							**$3**	**$2,706**	**$2**	**$1,890**	**$9**	**$7,448**
Estimated Savings - %								**17%**		**12%**		**47%**
Quote Expiration							6/30/2011		6/30/2011		6/30/2014	

SET SEG

Vision Plan Summary

Royal Oak Public Schools

Secretaries

Assumed Effective Date: 12/1/2010

Current Plan(s) and Segment:			1P	2P	FF	Monthly Composite	Total Annual Cost	Rate Period
Secretaries Pak A		Census			4	$21.21	$1,018	7/1/2010 - 6/30/2011
	MESSA VSP Plan 3	Rate	$21.21	$21.21	$21.21			
Secretaries Pak C		Census	7	35	14	$18.85	$12,667	7/1/2010 - 6/30/2011
	MESSA VSP Plan 3	Rate	$18.85	$18.85	$18.85			
Secretaries Pak B		Census		5	3	$21.21	$2,036	7/1/2010 - 6/30/2011
	MESSA VSP Plan 3	Rate	$21.21	$21.21	$21.21			
		TOTALS:	**7**	**40**	**21**		**$15,721**	

Product Name	1P	2P	FF	Monthly Composite	Total Annual Cost	Estimated Annual Savings
SET UltraVision Plan 3 - $65 Frames	$12.54	$34.45	$34.45	$32.20	$26,273	-$10,551
SET Vision Self-funded Plan 3 - $65 Frames	$15.95	$15.95	$15.95	$15.95	$13,015	$2,706
UHCV Platinum	$16.95	$16.95	$16.95	$16.95	$13,831	$1,890
NVA VSP Plan 3 Match	$5.04	$9.34	$13.36	$10.14	$8,273	$7,448
MESSA VSP Plan 3	Declined					

SET SEG

Vision Plan Comparison

DISCLAIMER: This document is a summary of certain plan features. It should not be interpreted as a complete comparison of the products represented.

Royal Oak Public Schools

Psychologists, Administrators and Non Affiliated

CURRENT PLAN

	Psychologists, Administrators and Non Affiliated		NVA VSP Plan 3 Match	
Name				
Carrier	SET Vision Self-funded Plan 5		NVA	
Rate Period	7/1/2010 - 6/30/2011		12/1/2010 - 6/30/2014	
Purchased Plan Features	**In Network**	**Out of Network Allowance**	**In Network**	**Out of Network Allowance**
Optometrist Exam	$55	$55	100%	$35
Ophthalmologist Exam	$55	$55	100%	$45
Regular Lenses	$73	$73	100%	$38
Bifocal Lenses	$84	$84	100%	$60
Trifocal Lenses	$100	$100	100%	$72
Lentiuclar Lenses	$124	$124	100%	$108
Frames	$75	$50	$65	$55
Necessary Contacts	$110	$110	$115	$115
Cosmetic Contacts	$110	$110	$115	$115
Exam Copay	$0.00	n/a	$0.00	n/a
Material Copay	$0.00	n/a	$0.00	n/a
Purchased Plan Rates	**Census**	**Rates**	**Census**	**Rates**
One Person (1P)	5	$10.68	5	$5.04
Two Person (2P)	13	$10.68	13	$9.34
Family (FF)	17	$10.68	17	$13.36
Projected Increase (0%)	0%			
Total Annual Premium	**35**	**$4,486**	**35**	**$4,485**
Combined Annual Premium	**$4,486**			
Estimated Savings - $			**$0**	**$1**
Estimated Savings - %				**0%**
Quote Expiration			6/30/2014	

NOTE: Current rate based on on actual claim data

SET SEG

Vision Plan Summary

Royal Oak Public Schools
Psychologists, Administrators and Non Affiliated
Assumed Effective Date: 12/1/2010

Current Plan(s) and Segment:		1P	2P	FF	Monthly Composite	Total Annual Cost	Rate Period
Psychologists, Administrators and Non Affiliated	Census	5	13	17	$10.68	$4,486	7/1/2010 - 6/30/2011
SET Vision Self-funded Plan 5	Rate	$10.68	$10.68	$10.68			
	TOTALS:	**5**	**13**	**17**		**$4,486**	

Product Name	1P	2P	FF	Monthly Composite	Total Annual Cost	Estimated Annual Savings
SET UltraVision Plan 3 - $75 Frames	$13.09	$35.96	$35.96	$32.69	$13,730	-$9,244
UHCV Platinum	$16.95	$16.95	$16.95	$16.95	$7,119	-$2,633
NVA VSP Plan 3 Match	$5.04	$9.34	$13.36	$10.68	$4,485	$1
MESSA VSP Plan 3	Declined					

SET SEG

Vision Plan Comparison

Royal Oak Public Schools
All Employees

DISCLAIMER: This document is a summary of certain plan features. It should not be interpreted as a complete comparison of the products represented.

	CURRENT PLAN		CURRENT PLAN		CURRENT PLAN		CURRENT PLAN		CURRENT PLAN		CURRENT PLAN		CURRENT PLAN	
Name	**Teachers Pak A**		**Teachers Pak C**		**Teachers Pak B**		**Secretaries Pak A**		**Secretaries Pak C**		**Secretaries Pak B**		**Psychologists, Administrators and Non Affiliated**	
Carrier	**MESSA VSP Plan 3**		**MESSA VSP Plan 3**		**MESSA VSP Plan 3**		**MESSA VSP Plan 3**		**MESSA VSP Plan 3**		**MESSA VSP Plan 3**		**SET Vision Self-funded Plan 5**	
Rate Period	7/1/2010 - 6/30/2011		7/1/2010 - 6/30/2011		7/1/2010 - 6/30/2011		7/1/2010 - 6/30/2011		7/1/2010 - 6/30/2011		7/1/2010 - 6/30/2011		7/1/2010 - 6/30/2011	
Purchased Plan Features	**In Network**	**Out of Network Allowance**	**In Network**	**Out of Network Allowance**	**In Network**	**Out of Network Allowance**	**In Network**	**Out of Network Allowance**	**In Network**	**Out of Network Allowance**	**In Network**	**Out of Network Allowance**	**In Network**	**Out of Network Allowance**
Optometrist Exam	100%	$35	100%	$35	100%	$35	100%	$35	100%	$35	100%	$35	$55	$55
Ophthalmologist Exam	100%	$45	100%	$45	100%	$45	100%	$45	100%	$45	100%	$45	$55	$55
Regular Lenses	100%	$38	100%	$38	100%	$38	100%	$38	100%	$38	100%	$38	$73	$73
Bifocal Lenses	100%	$60	100%	$60	100%	$60	100%	$60	100%	$60	100%	$60	$84	$84
Trifocal Lenses	100%	$72	100%	$72	100%	$72	100%	$72	100%	$72	100%	$72	$100	$100
Lentiuclar Lenses	100%	$108	100%	$108	100%	$108	100%	$108	100%	$108	100%	$108	$124	$124
Frames	$65	$55	$65	$55	$65	$55	$65	$55	$65	$55	$65	$55	$75	$50
Necessary Contacts	$115	$115	$115	$115	$115	$115	$115	$115	$115	$115	$115	$115	$110	$110
Cosmetic Contacts	$115	$115	$115	$115	$115	$115	$115	$115	$115	$115	$115	$115	$110	$110
Exam Copay	$0.00	n/a	$0.00	n/a	$0.00	n/a	$0.00	n/a	$0.00	n/a	$0.00	n/a	$0.00	n/a
Material Copay	$0.00	n/a	$0.00	n/a	$0.00	n/a	$0.00	n/a	$0.00	n/a	$0.00	n/a	$0.00	n/a
Purchased Plan Rates	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**
One Person (1P)	7	$17.44	36	$18.60	2	$20.18	0	$21.21	7	$18.85	0	$21.21	5	$10.68
Two Person (2P)	6	$17.44	45	$18.60	6	$20.18	0	$21.21	35	$18.85	5	$21.21	13	$10.68
Family (FF)	10	$17.44	139	$18.60	15	$20.18	4	$21.21	14	$18.85	3	$21.21	17	$10.68
Projected Increase (0%)	0%		0%		0%		0%		0%		0%		0%	
Total Annual Premium	**23**	**$4,813**	**220**	**$49,104**	**23**	**$5,570**	**4**	**$1,018**	**56**	**$12,667**	**8**	**$2,036**	**35**	**$4,486**
Combined Annual Premium	**$79,694**		**< TOTALS**		**< TOTALS**		**< TOTALS**		**< TOTALS**		**< TOTALS**		**< TOTALS**	
Estimated Savings - $														
Estimated Savings - %														
Quote Expiration														

NOTE: Psychologists, Administrators and Non Affiliated current rate based on actual claim data

SET SEG

Vision Plan Comparison

Royal Oak Public Schools
All Employees

DISCLAIMER: This document is a summary of certain plan features. It should not be interpreted as a

	SET Vision Self-funded Plan 3 - $65 Frames		UHCV Platinum		NVA VSP Plan 3 Match	
Name						
Carrier	SET TPA		United Healthcare Vision		NVA	
Rate Period	12/1/2010 - 6/30/2011		12/1/2010 - 6/30/2011		12/1/2010 - 6/30/2014	
Purchased Plan Features	**In Network**	**Out of Network Allowance**	**In Network**	**Out of Network Allowance**	**In Network**	**Out of Network Allowance**
Optometrist Exam	$64	$64	100%	$45	100%	$35
Ophthalmologist Exam	$64	$64	100%	$45	100%	$45
Regular Lenses	$84	$84	100%	$56	100%	$38
Bifocal Lenses	$96	$96	100%	$90	100%	$60
Trifocal Lenses	$120	$120	100%	$110	100%	$72
Lentiuclar Lenses	$144	$144	100%	$138	100%	$108
Frames	$65	$65	$130	$66	$65	$55
Necessary Contacts	$200	$200	100%	$200	$115	$115
Cosmetic Contacts	$200	$200	$200	$200	$115	$115
Exam Copay	$0.00	n/a	$0.00	n/a	$0.00	n/a
Material Copay	$0.00	n/a	$0.00	n/a	$0.00	n/a
Purchased Plan Rates	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**
One Person (1P)	57	$15.00	57	$16.95	57	$5.04
Two Person (2P)	110	$15.00	110	$16.95	110	$9.34
Family (FF)	202	$15.00	202	$16.95	202	$13.36
Projected Increase (0%)						
Total Annual Premium	**369**	**$66,420**	**369**	**$75,055**	**369**	**$48,161**
Combined Annual Premium						
Estimated Savings - $	**$3**	**$13,274**	**$1**	**$4,640**	**$7**	**$31,533**
Estimated Savings - %		**17%**		**6%**		**40%**
Quote Expiration	6/30/2011		6/30/2011		6/30/2014	

SET SEG

Vision Plan Summary

Royal Oak Public Schools
All Employees
Assumed Effective Date: 12/1/2010

Current Plan(s) and Segment:		1P	2P	FF	Monthly Composite	Total Annual Cost	Rate Period
Teachers Pak A	Census	7	6	10	$17.44	$4,813	7/1/2010 - 6/30/2011
MESSA VSP Plan 3	Rate	$17.44	$17.44	$17.44			
Teachers Pak C	Census	36	45	139	$18.60	$49,104	7/1/2010 - 6/30/2011
MESSA VSP Plan 3	Rate	$18.60	$18.60	$18.60			
Teachers Pak B	Census	2	6	15	$20.18	$5,570	7/1/2010 - 6/30/2011
MESSA VSP Plan 3	Rate	$20.18	$20.18	$20.18			
Secretaries Pak A	Census			4	$21.21	$1,018	7/1/2010 - 6/30/2011
MESSA VSP Plan 3	Rate	$21.21	$21.21	$21.21			
Secretaries Pak C	Census	7	35	14	$18.85	$12,667	7/1/2010 - 6/30/2011
MESSA VSP Plan 3	Rate	$18.85	$18.85	$18.85			
Secretaries Pak B	Census		5	3	$21.21	$2,036	7/1/2010 - 6/30/2011
MESSA VSP Plan 3	Rate	$21.21	$21.21	$21.21			
Psychologists, Administrators and Non Affiliated	Census	5	13	17	$10.68	$4,486	7/1/2010 - 6/30/2011
SET Vision Self-funded Plan 5	Rate	$10.68	$10.68	$10.68			
	TOTALS:	**57**	**110**	**202**		**$79,694**	

Product Name	1P	2P	FF	Monthly Composite	Total Annual Cost	Estimated Annual Savings
SET UltraVision Plan 3 - $65 Frames	$12.54	$34.45	$34.45	$31.07	$137,568	-$57,874
SET Vision Self-funded Plan 3 - $65 Frames	$15.00	$15.00	$15.00	$15.00	$66,420	$13,274
UHCV Platinum	$16.95	$16.95	$16.95	$16.95	$75,055	$4,640
NVA VSP Plan 3 Match	$5.04	$9.34	$13.36	$10.88	$48,161	$31,533
MESSA VSP Plan 3	Declined					

Vision Plan Disclaimers:

Please take note of the following disclaimers if you are interested in a vision plan shown within this proposal.

SET SEG UltraVision Insured:

UltraVision Insured plans are not exact matches to current plans. Please refer to plan summary page for details.

UltraVision plans do not require member to use a network provider. Benefit levels are the same regardless of network affiliation.

SET SEG Self Funded:

Self Funded rates are illustrative and may vary based on actual claims.

Self Funded plans are not exact matches to current plans. Please refer to plan summary page for details.

National Vision Administrators (NVA):

NVA plans require a minimum participation of 10 subscribers.

SET SEG
School Insurance Specialists

Self-Funded Vision Savings Projection

Royal Oak Public Schools

Estimated Costs and Savings:

Self-funded savings considerations:
- Benefits include annual and lifetime maximums
- Plan includes coordination of benefits (COB)
- Complete claims reports are provided

Fully Insured Costs:

Segment		Teachers	Secretaries	Teachers, Secretaries, Psychologists, Admistrators and Non-Affiliated
Number of Insureds		266	68	369
Approximate Monthly Premium per Employee (Insured)		$ 19	$ 19	$ 18
Approximate Annual Premium per Employee (Insured)		$ 224	$ 232	$ 216
Approximate Total Monthly District Premium Expense		$ 4,958	$ 1,310	$ 6,642
Approximate Total Annual District Premium Expense		$ 59,499	$ 15,724	$ 79,704
Self-Funded Costs:				
Set-Up Fee (one-time)		$ 350	$ 200	$ 350
Monthly Administrative Fee	$1.50 /mo	$ 399	$ 102	$ 554
Annual Administrative Fee		$ 4,788	$ 1,224	$ 6,642
Claims Fund:				
Two Months of Estimated Premium		$ 10,000	$ 3,000	$ 14,000
Loss Ratio: (Average)		75%	75%	75%
Analysis:				
Estimated Claims (annual premium x loss ratio)		$ 44,625	$ 11,794	$ 59,778
Administrative Fees		$ 4,788	$ 1,224	$ 6,642
Set-Up Fee (one-time)		$ 350	$ 200	$ 350
Total Estimated Self-Funded Costs (claims + fees)		$ 49,413	$ 13,018	$ 66,420
Fully Insured Costs (annual)		$ 59,499	$ 15,724	$ 79,704
Estimated Savings		**$ 10,086**	**$ 2,706**	**$ 13,284**
Self-Funded Composite Rate		**15.48**	**15.95**	**15.00**

SET SEG
School Insurance Specialists

SET Self-Funded Vision Proposal
Royal Oak Public Schools

BENEFIT YEAR

- Dental: January 1 through December 31
- Vision: July 1 through June 30.

CLAIM FUND

- The claim fund will be in the amount equal to two months of actual claims or two months of the current insured premium.
- Subsequent months will be the amount actually paid in claims the prior month.
- District will be invoiced by the 5th of each month.
- District will remit payment by the 20th of the month.

Segment	Setup Fee
Teachers	$ 350
Secretaries	$ 200
Teachers, Secretaries, Psychologists, Administrators and Non-Affiliated	$ 350

*When both SET Self-Funded Dental & Vision plans are purchased together, the monthly administrative fee per employee is reduced from $3.25 to $3.00 for Dental and from $1.50 to $1.25 for Vision.

CLAIM REPORTS

- SET SEG will provide monthly reports

MISCELLANEOUS:

- Customized benefit brochures will be provided at no cost to the district.
- Please note that a 30-day lead-time is required to effectuate benefits.

ADVANTAGES WITH SET

- ✓ **Guaranteed accurate administration of contract.**
- ✓ **Coordination of Benefits (C.O.B.)**
- ✓ **Availability of passive SET Dental Network (ADN network) for additional fee ($1.50 per employee/per month or 12% of re-priced claims)**
- ✓ **Plan design flexibility**
- ✓ **Opportunity for lower cost**
- ✓ **Continuation of current benefit levels**

Benefit Summaries

SET SEG
School Insurance Specialists

Ultra-Vision Plan 3
Benefits-at-a-Glance

Royal Oak Public Schools
All Employees

Basic Benefits

Note: There is no network for this plan. You may select any vision provider that you wish to use. Your benefit levels remain the same with any provider.	
Examination	$64.00 covered once every 12 months*
Regular Lenses	$84.00 covered once every 12 months*
Bifocal Lenses	$96.00 covered once every 12 months*
Trifocal Lenses	$120.00 covered once every 12 months*
Progressive Lenses	$144.00 covered once every 12 months*
Frame Allowance	$65.00 covered once every 12 months*
Contact Lenses	$200.00 covered once every 12 months*
Examinations, frames, and one set of corrective lenses (regular glasses, prescription sunglasses, photogray lenses or contact lenses) will be provided once in a 12 month period, defined as July 1 to June 30 of the following year, for each eligible member of the family.	
Additional charges for tint, oversized lenses, blended bifocal, and scratch or anti-glare coatings are not covered.	
* This amount will be paid toward items and services incurred in connection with your appointment regardless of the amount charged by your provider. The remaining balance is your responsibility.	

Monthly Rates until July 1, 2011

Self-funding Option
See attached Self-funded Vision Agreement for applicable administrative and setup fees.

SET SEG
School Insurance Specialists

UnitedHealthcare Vision℠

SET/UnitedHealthcare Vision Platinum Plan Benefits-at-a-Glance

This is intended to be an-easy-to-read summary. The group policy is the governing document.

Basic Benefits	In-Network	Out-of-Network
Eye Examination	100%	up to $45.00
Single Vision	100%	up to $56.00
Bifocal	100%	up to $90.00
Trifocal	100%	up to $110.00
Lenticular	100%	up to $138.00
Frames	100%*	up to $66.00
Elective Contact Lenses **Covered-in-full contacts** **All other elective contacts**	 100% up to $200.00	 up to $200.00 up to $200.00
Necessary Contact Lenses	100%	up to $210.00

Network Benefits – $0 Exam and $0 materials copays and patient options are paid to the network provider by the plan participant. Covered lens options include: Standard progressives, scratch resistant coating, tints and UV. Exams, lenses and frames are covered once every 12 months from last date of service.

Out-of-Network Benefits – The plan participant pays full fee to the provider and UnitedHealthcare Vision (UHCV) reimburses the participant for services rendered up to maximum allowance. There are no copays or deductibles.

***Frame Benefit** –With UHCV's frame benefit, all frames with a $50 wholesale cost or less are covered-in-full at private practice providers. For any frame with a wholesale cost greater than $50 at private practice providers, the participant only pays the difference between the wholesale cost of the frame and the $50 allowance. Plan participants receive a maximum $130 frame allowance for frames purchased at retail chain providers.

Contact lenses are provided in lieu of spectacle lenses and frames. UHCV's contact lens benefit covers in-full (after applicable copay) the fitting/evaluation fees, contacts (disposable contacts/up to 8 boxes, depending on prescription and plan selected), and up to two follow-up visits. A $200 allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside of UHCV's covered-in-full contacts (materials copay does not apply). Toric, gas permeable, and bifocal contacts are all examples of contacts that are outside of our covered-in-full selection.

Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following cataract surgery; To correct extreme vision problems that cannot be corrected with spectacle lenses; With certain conditions of anisometropia; With certain conditions of keratoconus.

Locate a network provider at www.uhcspecialtybenefits.com

SET SEG
School Insurance Specialists

UnitedHealthcare Vision℠

	Bronze		Silver		Gold		Platinum	
Service	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Eye Exam	100%	$15	100%	$39	100%	$45	100%	$45
Single Lenses	100%	$20	100%	$47	100%	$56	100%	$56
Bifocal Lenses	100%	$24	100%	$81	100%	$90	100%	$90
Trifocal Lenses	100%	$30	100%	$101	100%	$110	100%	$110
Lenticular Lenses	100%	$40	100%	$119	100%	$138	100%	$138
Contact Lenses	$105	$105	$125	$125	$150	$150	$200	$200
Frames	$130	$80	$130	$44	$130	$66	$130	$66
Exam Co-pay	$10	n/a	$10	n/a	$0	n/a	$0	n/a
Lenses & Material Co-pay	$25	n/a	$10	n/a	$0	n/a	$0	n/a

Frequency of Benefits – Exams, lenses and frames are covered once every 12 months from last date of service.

Network Benefits – Any applicable lenses and materials co-pay and patient options are paid to the network provider by the plan participant. Covered lens options include: Standard progressives, scratch resistant coating, tints and UV.

Out-of-Network Benefits – The plan participant pays full fee to the provider and United Healthcare Vision (UHCV) reimburses the participant for services rendered up to maximum allowance. There are no copays or deductibles.

Lenses & Material Co-pay – Please see plan description above for any applicable participant co-pay.

Necessary Contact Lenses are determined at the provider's discretion for one or more of the following conditions: Following cataract surgery; To correct extreme vision problems that cannot be corrected with spectacle lenses; With certain conditions of anisometropia; With certain conditions of keratoconus.

Frame Benefit –With UHCV's frame benefit, all frames with a $50 wholesale cost or less are covered-in-full at private practice providers. For any frame with a wholesale cost greater than $50 at private practice providers, the participant only pays the difference between the wholesale cost of the frame and the $50 allowance. Plan participants receive a minimum $130 frame allowance for frames purchased at retail chain providers.

Contact Lenses are provided in lieu of spectacle lenses and frames. UHCV's contact lens benefit covers in-full (after applicable copay) the fitting/evaluation fees, contacts (disposable contacts/up to 4, 6, or 8 boxes, depending on prescription and plan selected), and up to two follow-up visits. The contact lenses allowance (see plan description above for allowance amounts) is applied toward the fitting/evaluation fees and purchase of contact lenses outside of UHCV's covered-in-full contacts (materials copay does not apply). Toric, gas permeable, and bifocal contacts are all examples of contacts that are outside of our covered-in-full selection.

SET SEG

National Vision Administrators, L.L.C.
A vision care management company

Proposed Schedule of Benefits - VSP 3 Match

Benefit	In-Network	Out-of-Network
Examination - Once every 12 months	Covered 100%	(Reimbursed Amounts) Up to: Optometrist - $35
Lenses - Once every 12 months	Standard Glass or Plastic Covered 100%	Single Vision Up to $38 Bi-focal Up to $60 Tri-focal Up to $72 Lenticular Up to $108
Lens Options - Once every 12 months		
-Standard Transitions	Covered 100%	N/A
-Photochromatic	Covered 100%	N/A
-Oversized	Covered 100%	N/A
-Color Tints/Color Coats*	Covered 100%	Single Vision Up to $42* Bi-focal Up to $70* Tri-focal Up to $84* Lenticular Up to $118*
-Polarized*	Covered 100%	Single Vision Up to $56* Bi-focal Up to $90* Tri-focal Up to $110* Lenticular Up to $138*
Frame - Once every 12 months	Covered up to $65 Retail Allowance (20% Discount off remaining balance over $65 allowance)****	Up to $55
Contact Lenses Once every 12 months	(In Lieu of Lenses/Frames)	(In Lieu of Lenses/Frames)
-Elective**	Covered up to $115 Retail Allowance (15% discount (Conventional) or 10% discount (Disposable) off remaining balance over $115)*****	Up to $115
-Medically Necessary***	Covered 100%	$200

Notes: If covered participants choose extra options they are responsible for the additional cost paid directly to the provider.

* Out of network reimbursement for color tints/color coats and polarized lenses includes standard lens allowance.

** Fitting and Follow-Up Fees are deducted from the Contact Lens Allowance shown above unless otherwise specified.

*** Prior Authorization required from NVA

**** Discount does not apply at Wal-Mart /Sam's Club locations

***** Discount does not apply at Wal-Mart /Sam's Club locations, Cole corporate locations or Contact Fill

Lens Options	Fixed Fees	Lens Options	Fixed Fees
UV Coatings	$12.00	Scratch-Resistant Coating (Standard)	$10.00
Anti-Reflective Coating (Standard)	$40.00	Progressives (Standard)	$50.00
Polycarbonate SV	$25.00	High Index	$55.00
Polycarbonate BI	$30.00	Blended Bifocals (Segment)	$30.00
Polycarbonate TRI	$30.00	**Note:** Fixed Prices are available in-network only. Fixed prices do not apply at Wal-Mart/Sam's Club locations.	

***To access the provider directory, please visit www.e-nva.com. Select "find providers" in the text, and enter provider search number 50981000101 in the Group Number field, enter zip and radius for your search.**
Provider search number will change upon enrollment.

SECTION I – OVERVIEW

ABOUT NATIONAL VISION ADMINISTRATORS, L.L.C.

National Vision Administrators, L.L.C. (NVA) a full-service managed vision care organization, is headquartered in Clifton, New Jersey, with offices in New York, Ohio, Pennsylvania, Tennessee and Wisconsin.

Founded in 1979 by its current chairman, Richard O. Ullman, NVA serves approximately 7 million lives nationwide.

NVA clients include:

- top Fortune 500 clients
- public and private companies
- managed care organizations
- school systems
- municipal, state and federal government agencies
- union groups
- healthcare coalitions

NVA offers an array of customized plans:

- fixed rate insured plans
- self-funded (ASO) plans
- disease management
- discount plans
- Contact Fill—contact lens mail-order replacement program
- LASIK discount programs

NVA's National Provider Network is comprised of approximately 32,000 highly trained private practitioners as well as **REGIONAL AND NATIONAL OPTICAL RETAILERS** (including **Wal-Mart**). The network includes:

- Ophthalmologists (M.D.)
- Optometrists (O.D.)
- Opticians

Through flexible plan designs, innovative client service platforms and advanced system technology, NVA has become a recognized leader in managed vision care with a 99.4 percent membership retention rate for over 29 years.

NVA Insured Program - National Network of Optical Retailers

Allegany Optical	Eyemasters	Rx Optical
Aurora Vision Center	For Eyes Optical	Sam's Optical
Bard Optical	General Vision Services	Sears Optical
Binyon's Eyeworld	Henry Ford Optimeyes	Shopko Optical
Boscovs Optical	Herslof Opticians	Site For Sore Eyes
Cambridge Eye Doctors	Hour Eyes	Standard Optical
Clarkson Eye Care Center	J C Penney Optical	Stein Optical
Cohen's Fashion Optical	Marion Eye Center	Sterling Optical
Crown Optical	My Eye Dr	Sterling Vision Care
Davis Duehr Dean	National Optometry	SVS Vision
Doctor's Valuvision	National Vision, Inc	Target Optical
Dr Bizer's Visionworld	Northeastern Eye Institute	Union Eye Care Center
Dr Tavel One Hour Optical	Optical Boutique	United Optical
Doctor's Visionworks	Optical Clinic	Visionworks
Eye Dr.	Optical Outlet	Vision World, Inc
EyeLand Optical	Optimart	Wisconsin Vision, Inc
Eyeglass World	Pearle Vision	Wal-Mart Vision Centers

*The above represents some of the optical retailers participating in NVA's National Network. Cole Managed Vision Care retains the right to choose which clients with whom their corporate locations participate. Cole Managed Vision Care franchise locations are included in all NVA programs.

*The above represents optical retailers participating in NVA's National Network. Cole Managed Vision Care retains the right to choose which clients with whom their corporate locations participate. All Cole Managed Vision Care franchise locations are included in all NVA programs.

SECTION II – PROGRAM DESCRIPTION

HOW THE NVA VISION PROGRAMS WORK

NVA provides a full range of vision care programs through a nationwide network of highly trained practitioners. Highlights of available features include:

- Flexible plan designs to meet the unique needs of our clients and plan participants
- Network access in all 50 states, the District of Columbia, and Puerto Rico
- Employer Paid, Contributory, and/or Voluntary programs available
- The NVA provider network allows participants to choose the type of practitioner they need
  - *Ophthalmologists (M.D.)*
  - *Optometrists (O.D.)*
  - *Opticians*
  - ***NATIONAL AND REGIONAL OPTICAL RETAILERS, (including Wal-Mart)***
- Interactive web site for plan participants and network practitioners
- No claim forms to complete (in-network)
- Vision Intersect—Disease Management Program
- Contact Fill—contact lens mail-order replacement program
- LASIK discount programs

Each member is issued an NVA identification card and comprehensive summary of benefits. The member presents their identification card to a participating private practitioner or optical retail provider at time of service. NVA and its providers complete of all the paperwork.

It is the provider's responsibility to verify eligibility, allowances and any applicable co-payments. There are no delays in service and best of all, there are no claim forms to complete.

Members do have the option of visiting an out-of-network provider for their vision care services. If they choose this option, they are responsible for all charges payable to the provider at time of service. The member must then submit a copy of the itemized receipt to NVA for reimbursement according to the proposed reimbursement schedule.

The reimbursement check will be made payable to the member and mailed directly to their home. However, NVA access to network providers is extensive, and we experience very low out-of-network utilization.

NVA VISION PLAN COMPONENTS

Comprehensive Eye Health/Wellness Examination and Vision Analysis

NVA National Network Practitioners perform a comprehensive examination, which includes, but is not limited to:

Health History (Physical and Ocular) – to be maintained in patient profile

- Complete Individual and Family health history
- Identify physical conditions and/or medications that may affect eyesight

Reason for Comprehensive Examination

- Assessment of complaints (if any)
- Review occupational (or recreational) visual demands

Current Prescription Analysis

- Evaluation of current lens prescription (if applicable)

External and Internal Eye Health/Wellness Evaluation

Examination for eye disorders which included (but are not limited to):

- Cataracts
- Macular Degeneration
- Glaucoma
- Dry Eye Syndrome
- Eye and lid conjunctiva

Testing (as professionally indicated)

- Eye Coordination
- Visual Acuity
- Refraction
- Visual Field Screening
- Intraocular Pressure (Tonometry)
- Dyschromatopsia (Color Blindness)
- Depth Perception

Disease Management Integration is available through our own Vision Intersect Program (if chosen by the group)

Dilated Fundus Examination (DFE) (as professionally indicated) – a diagnostic procedure that dilates/ enlarges the pupil with the use of mydriatic eye drops to obtain an enhanced view of the internal surface of the eye.

EYEGLASS LENSES:

NVA's vision programs offer the following standard eyeglass lenses in glass or plastic:

- Single Vision
- Bifocal
- Trifocal
- Lenticular

If a participant chooses to purchase lenses or lens enhancements not indicated in the proposed plan as directed by the group, they may do so. These lenses and lens enhancements will be available at the fixed pricing set by NVA and described in our proposed schedule of benefits. These fixed fees provide the participant the advantage of the NVA negotiated discounts.

EYEGLASS FRAMES: NVA participants are free to choose any frame at an NVA in-network provider location. There are no limitations to specific frame selection, frame brands or manufacturers.

NVA does not own or have any financial interest in a:

- FRAME MANUFACTURER
  Any frame in the practitioner's office is available up to the plan allowance or discount – an unlimited assortment. NVA does not have a frame tree, "Tower" or limiting selection. Our covered members can choose the frame/lenses/contact lenses that are professionally indicated by their provider and that fit their wearing habits. These choices include many of the top designer frames well known in the industry.

- OPTICAL RETAILER/CHAIN
  The practice of owning network locations is only in place for the financial gain of the managed vision care vendor and removes objectivity for auditing network locations and determining client satisfaction.

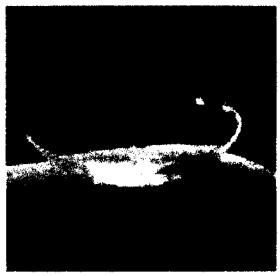
- OPTICAL LABORATORY
  NVA allows each of the NVA practitioners to utilize the same high level laboratory they utilize for their retail customers. This continuity of service level ensures the provider chooses the correct and most accurate laboratory to fabricate the eyewear based on the type of frame, lens and coatings prescribed. This flexibility for the practitioner encourages providers to join the NVA Team and expedites the delivery/dispensing of the eyewear by not having to utilize a central laboratory which in most cases is not local to network practitioner.

CONTACT LENSES are offered in lieu of frames and/or spectacle lenses. Additional professional services related to contact lenses (also known as Fitting Fees) are included in the Contact Lens Allowance. The contact lens benefit includes all types of contact lenses such as hard, soft, gas permeable, bifocal and disposable lenses offering NVA members a broader selection based on comfort and wearing habits.

(Unless otherwise specified in the plan and directed by the group).

SECTION III — NVA VALUE-ADDED SERVICES AT NO ADDITIONAL COST

Contact Fill — Contact Lens Mail Order Replacement Program



NVA offers a contact lens mail-order replacement program through its subsidiary, Contact Fill, L.L.C. Contact Fill offers all major brands of contact lenses including:

- Disposable
- Toric
- Cosmetic color-enhancing contacts

This additional benefit provides a significant savings and the added convenience of direct delivery at no cost to the plan. **Members can utilize their in network benefit through the Contact Fill program, no claim submission is required.**

Below are three different options for ordering and reordering lenses:

- **PHONE:** (866) CFI-1EYE (The average phone order takes less than four minutes to complete.)
- **FAX:** (866) 589-6969
- **MAIL:** Contact Fill, L.L.C.
  4909 Louise Drive
  Suite 116
  Mechanicsburg, PA 17055

A valid prescription is required to dispense contact lenses by mail.

Contact Fill's licensed optician will verify a participant's prescription with the provider, for phone and e-mail orders. All orders are shipped in unmarked packages via United Parcel Service or U.S. First Class Mail, and are dispensed from our Mechanicsburg, PA location.

To learn more, visit our website at **www.contactfill.com**.

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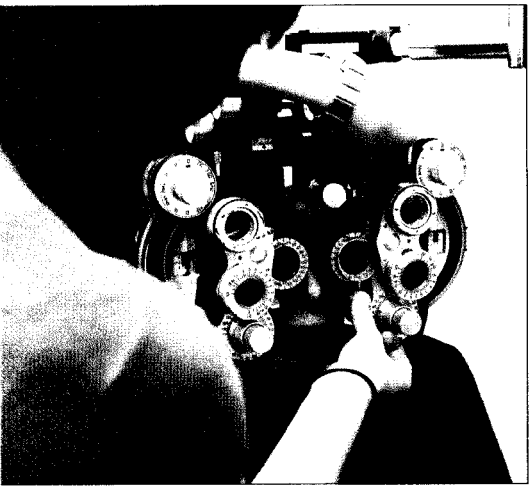

415 WEST KALAMAZOO ST. LANSING, MI 48933 PHONE: 800.292.5421 www.setseg.org