RENEWAL QUOTE

Group Name:	Southgate Community Schools		
Effective Date:	1/1/2018	Date Prepared:	10/2/2017
Marketing Rep:	Janet Hirth		
Broker ID:	0		
Broker:	KAONICK & COMPANY INC		
Address:			

Benefit Plan:

	Current Benefits	*Renewal Period*	*Alternative 1 Benefits*	*Alternative 2 Benefits*	*Alternative 3 Benefits*
Grandfathered Status	**Non-Grandfathered**	**Non-Grandfathered**			
Base Benefit Design	**Basic $250/$100**	**Basic $250/$100**			
Rx Benefit Option*	**$15/$30 Rx**	**$15/$30 Rx**			
Vision	**Yes**	**Yes**			
Hearing	**Yes**	**Yes**			
DME/Orthotics/Prosthetics	**Yes**	**Yes**			
Skilled Nursing Facility	**Yes**	**Yes**			
Elective Abortion	**No**	**No**			
Physician Office Visit Copay	**$20 OV**	**$20 OV**			
Emergency Room Copay	**$100 ER**	**$100 ER**			
Urgent Care Copay	**$40 UC**	**$40 UC**			
Domestic Partner Rider	**Excluded**	**Excluded**			
Calculated Rates					
Single	**$538.87**	**$562.09**			
Employee & Dependent	**$1,122.75**	**$1,171.12**			
Family	**$1,428.29**	**$1,489.82**			

Approximate average taxes & fees included per member per month	
MI Claims Tax (0.75% of Claims)	$3.58
Comparative Effectiveness Research	$0.19
Health Insurer Fee	$1.59
Total PMPM	**$5.36**

*All renewal non-Grandfathered plans are subject to a combined medical/Rx maximum out-of-pocket

Total Health Care USA reserves the right to adjust final rates if any assumptions or information provided during the quoting process changes or is incorrect. Final rates will be determined by Total Health Care USA underwriting based on actual group enrollment and participation.

HMO Basic 250/100

BENEFIT INFORMATION	
BENEFIT PERIOD: Calendar year	
Medical Deductible	$0 Annual per Member $0 Annual per Family
Coinsurance	0%
Combined Out-of-Pocket Maximum	$3,000 per Member $6,000 per Family
PHYSICIAN/PREVENTIVE SERVICES	
Primary Care Visit	$20 Co-Pay
Specialty Care	$40 Co-Pay
Preventive Care/Screening/Immunizations	100% Coverage
Prenatal and Postnatal Care	100% Coverage
Well Baby Visits	100% Coverage
Allergy Injections	100% Coverage
Allergy Testing	100% Coverage
Chiropractic Care (Limited to 30 visits per calendar year in combination with PT/OT)	100% Coverage
PT/OT (Limited to 30 visits per calendar year in combination with Chiropractic Care)	100% Coverage
Rehabilitative & Habilitative Devices	100% Coverage
Rehabilitative Speech Therapy (30 visits per calendar year)	100% Coverage
Diabetes Education	100% Coverage
Dietician Services (Nutritional Counseling)	100% Coverage
Family Planning	100% Coverage
Habilitation Services	100% Coverage
Infertility Testing (Underlying causes only)	100% Coverage
Mammograms	100% Coverage
Weight Loss Programs	100% Coverage
INPATIENT SERVICES	
Inpatient Stay	$250 Co-Pay
Inpatient Physician & Surgical Services	100% Coverage
Bariatric Surgery (One procedure per lifetime)	$250 Co-Pay
Delivery & All Inpatient Services for Maternity Care	$250 Co-Pay
Reconstructive Surgery	$250 Co-Pay
Transplant	$250 Co-Pay
OUTPATIENT SERVICES	
Outpatient Surgery Physician/Surgical Services	100% Coverage
Outpatient Facility Fee	$100 Co-Pay
Outpatient Rehabilitation Services (Includes Cardio/Pulmonary Rehab)	100% Coverage
Chemotherapy	100% Coverage
Dialysis	100% Coverage
Imaging (CT/PET Scans, MRIs)	100% Coverage
Infusion Therapy	100% Coverage
Laboratory Outpatient & Professional Services	100% Coverage
Radiation Therapy	100% Coverage
Temporomandibular Joint Disorders	50% Coverage
X-Rays & Diagnostic Imaging	100% Coverage
EMERGENCY/AFTER HOURS MEDICAL SERVICES	
Emergency Room	$100 Co-Pay
Urgent Care	$40 Co-Pay
Ambulance Services (When medically necessary)	$75 Co-Pay

HMO Basic 250/100

BENEFIT INFORMATION	
MENTAL HEALTH/SUBSTANCE ABUSE SERVICES	
Mental/Behavioral Health Outpatient Services	$40 Co-Pay
Mental/Behavioral Health Inpatient Services	$250 Co-Pay
Substance Abuse Outpatient	$40 Co-Pay
Substance Abuse Inpatient Services	$250 Co-Pay
OTHER SERVICES	
Home Health Care	100% Coverage
Skilled Nursing Facility (Limited to 45 days per calendar year)	100% Coverage
Hospice Services	100% Coverage
DURABLE MEDICAL EQUIPMENT/PROSTHETIC DEVICES	
DME	100% Coverage by Plan's DME Provider
Prosthetic Devices	100% Coverage
HEARING SERVICES	
Hearing Exam	100% Coverage
Hearing Aids	Plan pays a max $600 per ear every 3 years
VISION SERVICES	
Routine Eye Exam (Adult & Pediatric)	100% Coverage
Eye Glasses for Adults	100% Coverage on selected lenses & frames
Eye Glasses for Children	100% Coverage on selected lenses & frames
DENTAL SERVICES	
Accidental Dental	Not Covered
PHARMACY	
Generic Drugs	See Pharmacy Rider
Preferred Brand Name Drugs	See Pharmacy Rider
Non-Preferred Brand Name Drugs	See Pharmacy Rider
Specialty Drugs	See Pharmacy Rider
90-day supply Medications available through Plan's Mail Order Pharmacy	See Pharmacy Rider

The Benefits described above are intended to be only a Summary Description. For details, please review the Certificate of Coverage Agreement.

$15.00/ $30.00 COPAY PRESCRIPTION DRUG RIDER

This Rider is issued in conjunction with the Group's Certificate of Coverage Agreement and Prescription Drug Rider.

All definitions, terms, conditions, exclusions and limitations in the Certificate of Coverage Agreement and the Prescription Drug Rider shall remain unchanged except as provided in this Rider.

I. LIMITATIONS

1.01 **Co-payment at an Affiliated Pharmacy**: When a prescription is filled in accordance with Section II, Authorized Benefits and Services of the Prescription Drug Rider, member shall pay the pharmacy a co-payment of $15.00 for generic drugs and $30.00 or 50% of Total Health Care's reimbursement, whichever is less, for brand name drugs.

1.02 **Co-payment at an Affiliated Mail Order Pharmacy**: When a Maintenance Medication is filled in accordance with Section II, Authorized Benefits and Services; member shall pay the pharmacy a co-payment of $30.00 for a 90 day supply of generic drugs, and $60.00 for a 90 day supply of brand-name drugs.

MEC

RENEWAL QUOTE

Group Name:	Southgate Community Schools		
Effective Date:	1/1/2018	Date Prepared:	9/28/2017
Marketing Rep:	Janet Hirth		
Broker ID:	0		
Broker:	KAONICK & COMPANY INC		
Address:			

Benefit Plan:

	Current Benefits	*Renewal Period*	*Alternative 1 Benefits*	*Alternative 2 Benefits*	*Alternative 3 Benefits*
Grandfathered Status	**Non-Grandfathered**	**Non-Grandfathered**			
Base Benefit Design	**Basic $3,000 Deductible**	**Basic $3,000 Deductible**			
Rx Benefit Option*	**$30/$60 Rx**	**$30/$60 Rx**			
Vision	**Yes**	**Yes**			
Hearing	**Yes**	**Yes**			
DME/Orthotics/Prosthetics	**Yes**	**Yes**			
Skilled Nursing Facility	**Yes**	**Yes**			
Elective Abortion	**No**	**No**			
Physician Office Visit Copay	**$30 OV**	**$30 OV**			
Emergency Room Copay	**$200 ER**	**$200 ER**			
Urgent Care Copay	**$60 UC**	**$60 UC**			
Domestic Partner Rider	**Excluded**	**Excluded**			
Calculated Rates					
Single	**$345.18**	**$378.10**			
Employee & Dependent	**$719.19**	**$787.78**			
Family	**$914.90**	**$1,002.16**			

Approximate average taxes & fees included per member per month

MI Claims Tax (0.75% of Claims)	$2.41
Comparative Effecliveness Research	$0.19
Health Insurer Fee	$1.59
Total PMPM	**$4.19**

*All renewal non-Grandfathered plans are subject to a combined medical/Rx maximum out-of-pocket

Total Health Care USA reserves the right to adjust final rates if any assumptions or information provided during the quoting process changes or is incorrect. Final rates will be determined by Total Health Care USA underwriting based on actual group enrollment and participation.

HMO Basic $3,000 Deductible

BENEFIT INFORMATION	
BENEFIT PERIOD: Calendar year	
Medical Deductible	$3,000 Annual per Member $6,000 Annual per Family
Coinsurance	0%
Combined Out-of-Pocket Maximum	$4,000 per Member $8,000 per Family
PHYSICIAN/PREVENTIVE SERVICES	
Primary Care Visit	$30 Co-Pay
Specialty Care	$60 Co-Pay
Preventive Care/Screening/Immunizations	100% Coverage
Prenatal and Postnatal Care	100% Coverage
Well Baby Visits	100% Coverage
Allergy Injections	100% Coverage
Allergy Testing	100% Coverage
Chiropractic Care (Limited to 30 visits per calendar year in combination with PT/OT)	100% Coverage after Deductible
PT/OT (Limited to 30 visits per calendar year in combination with Chiropractic Care)	100% Coverage after Deductible
Rehabilitative & Habilitative Devices	100% Coverage after Deductible
Rehabilitative Speech Therapy (30 visits per calendar year)	100% Coverage after Deductible
Diabetes Education	100% Coverage
Dietician Services (Nutritional Counseling)	100% Coverage
Family Planning	100% Coverage
Habilitation Services	100% Coverage after Deductible
Infertility Testing (Underlying causes only)	100% Coverage after Deductible
Mammograms	100% Coverage
Weight Loss Programs	100% Coverage
INPATIENT SERVICES	
Inpatient Stay	100% Coverage after Deductible
Inpatient Physician & Surgical Services	100% Coverage after Deductible
Bariatric Surgery (One procedure per lifetime)	100% Coverage after Deductible
Delivery & All Inpatient Services for Maternity Care	100% Coverage after Deductible
Reconstructive Surgery	100% Coverage after Deductible
Transplant	100% Coverage after Deductible
OUTPATIENT SERVICES	
Outpatient Surgery Physician/Surgical Services	100% Coverage after Deductible
Outpatient Facility Fee	100% Coverage after Deductible
Outpatient Rehabilitation Services (Includes Cardio/Pulmonary Rehab)	100% Coverage after Deductible
Chemotherapy	100% Coverage after Deductible
Dialysis	100% Coverage after Deductible
Imaging (CT/PET Scans, MRIs)	100% Coverage after Deductible
Infusion Therapy	100% Coverage after Deductible
Laboratory Outpatient & Professional Services	100% Coverage after Deductible
Radiation Therapy	100% Coverage after Deductible
Temporomandibular Joint Disorders	50% Coverage
X-Rays & Diagnostic Imaging	100% Coverage after Deductible
EMERGENCY/AFTER HOURS MEDICAL SERVICES	
Emergency Room	$200 Co-Pay
Urgent Care	$60 Co-Pay
Ambulance Services (When medically necessary)	$75 Co-Pay

HMO Basic $3,000 Deductible

BENEFIT INFORMATION	
MENTAL HEALTH/SUBSTANCE ABUSE SERVICES	
Mental/Behavioral Health Outpatient Services	$60 Co-Pay
Mental/Behavioral Health Inpatient Services	100% Coverage after Deductible
Substance Abuse Outpatient	$60 Co-Pay
Substance Abuse Inpatient	100% Coverage after Deductible
OTHER SERVICES	
Home Health Care	100% Coverage after Deductible
Skilled Nursing Facility (Limited to 45 days per calendar year)	100% Coverage after Deductible
Hospice Services	100% Coverage
DURABLE MEDICAL EQUIPMENT/PROSTHETIC DEVICES	
DME	100% Coverage by Plan's DME Provider
Prosthetic Devices	100% Coverage after Deductible
HEARING SERVICES	
Hearing Exam	100% Coverage
Hearing Aids	Plan pays a max $600 per ear every 3 years
VISION SERVICES	
Routine Eye Exam (Adult & Pediatric)	100% Coverage
Eye Glasses for Adults	100% Coverage on selected lenses & frames
Eye Glasses for Children	100% Coverage on selected lenses & frames
DENTAL SERVICES	
Accidental Dental	Not Covered
PHARMACY	
Generic Drugs	See Pharmacy Rider
Preferred Brand Name Drugs	See Pharmacy Rider
Non-Preferred Brand Name Drugs	See Pharmacy Rider
Specialty Drugs	See Pharmacy Rider
90-day supply Medications available through Plan's Mail Order Pharmacy	See Pharmacy Rider

The Benefits described above are intended to be only a Summary Description. For details, please review the Certificate of Coverage Agreement.

PRESCRIPTION DRUG RIDER
$30.00 GENERIC/$60 BRAND NAME

This Rider is issued in conjunction with the Certificate of Coverage Agreement.

All definitions, terms, conditions, exclusions, and limitations in the Certificate of Coverage Agreement shall remain unchanged except as provided in this Rider.

The following additional definitions, terms, conditions, exclusions, and limitations are applicable to the additional Authorized Benefits and Services provided by this Rider.

I. DEFINTIONS

1.01 "Affiliated Pharmacy" means a licensed pharmacist or mail order pharmacy who has a contract with the Plan to provide services to Members.

1.02 "Prescription Drug" means:

a) All prescription drugs, biologics, and compound medications, including birth control pills, which are listed in the Plan's formulary, as it may be amended from time to time, and

b) Injectible insulin and hypodermic needles and syringes used for the administration of insulin.

1.03 "Maintenance Medications" means, most extended use medications for the treatment medical conditions such as high blood pressure, arthritis, gastric reflux, depression, high cholesterol, thyroid conditions and seasonal allergies.

II. AUTHORIZED BENEFITS AND SERVICES

2.01 The Plan will cover Prescription Drugs:

a) When the prescription is filled by an Affiliated Pharmacy for a 30-day supply or Affiliated mail order pharmacy for a 90-day supply of certain Maintenance Medications; and

b) When the Prescription Drug was prescribed by an Affiliated Physician or prescribed by a Referral Physician and approved by an Affiliated Physician.

c) When a prescription is filled at a non-Affiliated Pharmacy outside the Plan's Service Area, the Plan will pay for a 30-day supply when the Member presents to the Plan a receipt showing payment for a Prescription Drug itemizing the Prescription Drug purchased; and

i. the member was outside the Plan's Service Area for a period of not less than thirty (30) consecutive days; or

ii. The Prescription Drug was not prescribed or approved by a Physician within the Plan's Service Area, but was ordered in the course of treating a Medical Emergency or Accidental Injury.

III. LIMITATIONS

3.01 **Co-payment at an Affiliated Pharmacy**: When a prescription is filled in accordance with Section II, Authorized Benefits and Services, member shall pay the pharmacy a co-payment of $30.00 for generic drugs, $60.00 for brand-name.

3.02 **Co-payment at an Affiliated Mail Order Pharmacy**: When a Maintenance Medication is filled in accordance with Section II, Authorized Benefits and Services, member shall pay the pharmacy a co-payment of $60.00 for a 90 day supply of generic drugs, and $120.00 for a 90 day supply of brand-name drugs. **Brand-name non-formulary drugs are excluded from mail order.**