SET SEG
School Insurance Specialists

Medical Rate Summary
Bellaire Public Schools
All Employees
Assumed Effective Date: 7/1/2016

Current Plan(s) and Segment:		1P	2P	FF		Total Annual Cost
Principal, Teacher, Bus Driver, Aide and Secretary Enrolled in MESSA Choices Plan	**Census**	3	7	5	15	
MESSA $500-0%; Saver Rx	**Rate**	$658.68	$1,479.78	$1,843.09		$258,599
Principal, Teacher, Bus Driver, Aide and Secretary Enrolled in MESSA ABC Plan 1	**Census**		1	9	10	
MESSA ABC Plan 1 $1300-0%; ABC Rx	**Rate**	$593.10	$1,332.20	$1,659.45		$195,207
	TOTALS:	3	8	14	**25**	**$453,806**

Product Name	1P Rate	2P Rate	FF Rate	Total Annual Cost	Estimated Annual Savings
MESSA Plans					
MESSA $1000-0%; Saver Rx	$621	$1,396	$1,738	$448,404	$5,402
BCBSM Small Group HSA Plans					
Simply Blue HSA PPO Gold $1300	$527	$1,103	$1,438	$366,453	$87,354
Simply Blue HSA PPO Gold $1350	$564	$1,179	$1,538	$391,919	$61,888
Simply Blue HSA PPO Gold $2700 ($700)	$474	$991	$1,292	$329,273	$124,534
BCBSM Small Group PPO Plans					
Simply Blue PPO Gold $500	$559	$1,169	$1,524	$388,441	$65,365
Simply Blue PPO Gold $1000	$538	$1,125	$1,468	$373,959	$79,847
Priority Health Small Group Options					
Priority Health POS 100 Platinum 250; $10/$40/$80/20%/20% Rx	$667	$1,396	$1,820	$463,856	-$10,049

Product Name	1P Rate	2P Rate	FF Rate	Total Annual Cost	Estimated Annual Savings
Priority Health POS 500-20%; $15/$15/$50/$80/20%/20% Rx	$545	$1,140	$1,487	$378,880	$74,927
Priority Health POS 500-20%; $10/$10/$40/$40/$40/$40 Rx	$548	$1,147	$1,495	$381,041	$72,765
Priority Health POS Extras 1000-20%; $5*/$15*/$50/$80/20%/20% Rx (*only generics before deductible)	$505	$1,055	$1,376	$350,640	$103,167
Priority Health POS HSA 1350-10%; $10/$10/$40/$80/20%/20% Rx	$506	$1,059	$1,381	$351,839	$101,967
Priority Health POS HSA 1350-10%; $10/$10/$40/$40/$40/$40 Rx	$508	$1,062	$1,385	$352,950	$100,856
Priority Health POS HSA 1685-20%; $20/$20/$60/$80/20%/20% Rx	$461	$965	$1,259	$320,702	$133,105
Priority Health POS HSA 2000-30%; $20/$20/$60/$80/20%/20% Rx	$434	$908	$1,184	$301,776	$152,030
Aetna	Did not provide a quote				

MESSA:

*MESSA rates include estimated blended taxes and fees for the 2016-2017 policy period.

BCBSM:

*BCBSM rates include certain federal taxes and fees established by the Affordable Care Act as well as certain State taxes and assessments. The figures are estimates and may change for future billings.

*BCBSM quoted rates do not include commissions paid to SET SEG. Fees for SET SEG services are addressed in a separate agreement. BCBSM rates may change based on final BCBSM underwriting guidelines, actual group enrollment and participation.

Priority Health:

*Priority Health rates, fees and/or claims projections include "Michigan claims tax", PPACA fees and assessments, or similar fees or taxes that may be imposed by the Federal Government or the State of Michigan.

*For BCBSM and Priority Health SET SEG applies the 1.5% administrative fee to census information provided by the district for the purposes of quoting. In the event that the census proves to be inaccurate and actual group enrollment and participation changes by more than 10%, the districts rates will be subject to change. The rate change may occur during any billing cycle of the current term as determined by SET SEG.

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

Bellaire Public Schools

All Employees

Assumed Effective Date: 7/1/2016

Plan	CURRENT PLAN Principal, Teacher, Bus Driver, Aide and Secretary Enrolled in MESSA Choices Plan MESSA $500-0%; Saver Rx		CURRENT PLAN Principal, Teacher, Bus Driver, Aide and Secretary Enrolled in MESSA ABC Plan 1 MESSA ABC Plan 1 $1300-0%; ABC Rx		Option 1 Simply Blue PPO Gold $500		Option 2 Simply Blue HSA PPO Gold $1350		Option 3 Priority Health POS 500-20%; $10/$10/$40/$40/$40/$40 Rx		Option 4 Priority Health POS HSA 1350-10%; $10/$10/$40/$40/$40/$40 Rx	
Rate Period	7/1/2016-6/30/2017		7/1/2016-6/30/2017		7/1/2016-6/30/2017		7/1/2016-6/30/2017		7/1/2016-6/30/2017		7/1/2016-6/30/2017	
Purchased Plan Features	**In Network**		**In Network**		**In Network**		**In Network**		**In Network**		**In Network**	
Deductible												
Annual Deductible - 1P	$500		$1,300		$500		$1,350		$500 (embedded)		$1,350 (aggregate)	
Annual Deductible - 2P/FF	$1,000		$2,600		$1,000		$2,700		$1,000 (embedded)		$2,700 (aggregate)	
Additional Cost After Deductible												
Employee Coinsurance after Deductible	0%		0%		20%		0%		20%		10%	
Coinsurance Max - 1P	$0		$1,000		$3,000		$1,000		$0		$1,050	
Coinsurance Max - 2P/FF	$0		$2,000		$6,000		$2,000		$0		$2,100	
Out of Pocket Maximum												
Max ded, coinsurance, copays - 1P	$1,500		$2,300		$6,600		$2,350		$5,000 (embedded)		$2,400 (aggregate)	
Max ded, coinsurance, copays - 2P/FF	$3,000		$4,600		$13,200		$4,700		$10,000 (embedded)		$4,800 (aggregate)	
Copayments												
Office Visit/Specialist	$20/$20		0% after Ded.		$20/$40		0% after Ded.		$20 before Ded./$35 before Ded.		10% after Ded.	
Urgent Care/ER	$25/$50		0% after Ded.		$60/$150		0% after Ded.		$75 before Ded./$150 after Ded.		10% after Ded.	
Chiropractic Limit/Copay	38/0% (office visit copay may apply)		38/0% after Ded.		30/$30 (combined with PT and OT)		30/0% after Ded. (combined with PT and OT)		30/$35 (combined with PT and OT)		30/10% after Ded. (combined with PT and OT)	
Rx Copay	Saver Rx		ABC Rx		$15/$50/50%/20%/25%		$20/$60/50%/20%/25% after Ded.		$10/$10/$40/$40/$40/$40 Rx		$10/$10/$40/$40/$40/$40 Rx after Ded.	
Total Monthly Costs	Census	Rates	Census	Rates	Census	Rates	Census	Rates	Census	Rates	Census	Rates
One Person (1P)	3	$658.68	0	$593.10	3	$558.95	3	$563.96	3	$548.30	3	$507.88
Two Person (2P)	7	$1,479.78	1	$1,332.20	8	$1,168.94	8	$1,179.40	8	$1,146.67	8	$1,062.13
Family (FF)	5	$1,843.09	9	$1,659.45	14	$1,524.41	14	$1,538.06	14	$1,495.37	14	$1,385.13
Total Annual Premium	15	$258,599	10	$195,207	25	$388,441	25	$391,919	25	$381,041	25	$352,950
Combined Current Lives	25		< TOTALS									
Combined Annual Premium	$453,806		< TOTALS									
Total Costs					**PEPM**	**Annual**	**PEPM**	**Annual**	**PEPM**	**Annual**	**PEPM**	**Annual**
Estimated Annual Cost	**$453,806**		**<Totals**		**$388,441**		**$391,919**		**$381,041**		**$352,950**	
Estimated Savings/(Increase) $					**$65,365.35**		**$61,887.74**		**$72,765.13**		**$100,856.41**	
Estimated Difference %					**14.4%**		**13.6%**		**16.0%**		**22.2%**	
Single (annual amounts)												
Taxes and Fees	Included in total plan cost		Included in total plan cost		Included in total plan cost		Included in total plan cost		Included in total plan cost		Included in total plan cost	
Total Plan Cost	$7,904.21		$7,117.18		$6,707.40		$6,767.47		$6,579.60		$6,094.56	
PA 152 Hard Cap	$6,142.11		$6,142.11		$6,142.11		$6,142.11		$6,142.11		$6,142.11	
Amount Over/Under Hard Cap	$1,762.10		$975.07		$565.29		$625.36		$437.49		-$47.55	
Two Person (annual amounts)												
Taxes and Fees	Included in total plan cost		Included in total plan cost		Included in total plan cost		Included in total plan cost		Included in total plan cost		Included in total plan cost	
Total Plan Cost	$17,757.31		$15,986.43		$14,027.24		$14,152.82		$13,760.04		$12,745.56	
PA 152 Hard Cap	$12,845.04		$12,845.04		$12,845.04		$12,845.04		$12,845.04		$12,845.04	
Amount Over/Under Hard Cap	$4,912.27		$3,141.39		$1,182.20		$1,307.78		$915.00		-$99.48	
Family (annual amounts)												
Taxes and Fees	Included in total plan cost		Included in total plan cost		Included in total plan cost		Included in total plan cost		Included in total plan cost		Included in total plan cost	
Total Plan Cost	$22,117.05		$19,913.44		$18,292.92		$18,456.69		$17,944.44		$16,621.56	
PA 152 Hard Cap	$16,751.23		$16,751.23		$16,751.23		$16,751.23		$16,751.23		$16,751.23	
Amount Over/Under Hard Cap	$5,365.82		$3,162.21		$1,541.69		$1,705.46		$1,193.21		-$129.67	

MESSA:

*MESSA rates include estimated blended taxes and fees for the 2016-2017 policy period.

Priority Health:

*BCBSM rates include certain federal taxes and fees established by the Affordable Care Act as well as certain State taxes and assessments. The figures are estimates and may change for future billings.

*BCBSM quoted rates do not include commissions paid to SET SEG. Fees for SET SEG services are addressed in a separate agreement. BCBSM rates may change based on final BCBSM underwriting guidelines, actual group enrollment and participation.

Priority Health:

*Priority Health rates, fees and/or claims projections include "Michigan claims tax", PPACA fees and assessments, or similar fees or taxes that may be imposed by the Federal Government or the State of Michigan.

*For BCBSM and Priority Health SET SEG applies the 1.5% administrative fee to census information provided by the district for the purposes of quoting. In the event that the census proves to be inaccurate and actual group enrollment and participation changes by more than 10%, the districts rates will be subject to change. The rate change may occur during any billing cycle of the current term as determined by SET SEG.

Dental Rate Summary
Bellaire Public Schools
All Employees
Assumed Effective Date: 7/1/2016

Current Plan(s) and Segment:		1P	2P	FF	Monthly Composite	Total Annual Cost	Rate Period
Principal Enrolled in Medical	**Census**			1	$128.72	$1,545	7/1/2016-6/30/2017
MESSA 80/80/80/80-1500/2900 Dental Plan	**Rate**	$31.83	$69.33	$128.72			
Bus Driver, Aide and Secretary Enrolled in Medical	**Census**		4		$67.48	$3,239	7/1/2016-6/30/2017
MESSA 80/80/80/80-1000/1300 Dental Plan	**Rate**	$34.29	$67.48	$115.84			
Bus Driver, Aide and Secretary Not Enrolled in Medical	**Census**			1	$102.74	$1,233	7/1/2016-6/30/2017
MESSA 80/80/80/80-1000/1300 Dental Plan	**Rate**	$30.50	$58.52	$102.74			
Teacher Enrolled in Medical	**Census**	3	4	13	$93.56	$22,455	7/1/2016-6/30/2017
MESSA 80/80/80/80-1500/2900 Dental Plan	**Rate**	$31.07	$60.71	$118.09			
Teacher Not Enrolled in Medical	**Census**		1	3	$125.65	$6,031	7/1/2016-6/30/2017
MESSA 100/90/90/90-1500/3200 Dental Plan	**Rate**	$35.68	$72.96	$143.21			
	TOTALS:	**3**	**9**	**18**		**$34,502**	

Product Name	Rate Period	1P Rate	2P Rate	FF Rate	Monthly Composite	Total Cost	Estimated Annual Savings
Principal Dental Plan	7/1/2016-6/30/2017	$37.52	$69.69	$142.25	$110.01	$39,603	-$5,101
ADN		declined to quote					
Guardian		declined to quote					
MetLife		declined to quote					

*Principal rates good for segment enrolling in current benefit plan.

*Principal rates include taxes and fees.

Vision Rate Summary
Bellaire Public Schools
All Employees
Assumed Effective Date: 7/1/2016

Current Plan(s) and Segment:			1P	2P	FF	Monthly Composite	Total Annual Cost	Rate Period
Principal and Teacher		**Census**	3	5	17	$27.56	$8,269	7/1/2016-6/30/2017
	VSP 3 Plus	**Rate**	$10.02	$21.54	$32.43			
Bus Driver, Aide and Secretary		**Census**		4	1	$13.63	$818	7/1/2016-6/30/2017
	VSP 2 Silver	**Rate**	$5.76	$12.38	$18.64			
		TOTALS:	**3**	**9**	**18**		**$9,087**	

Product Name	Rate Period	1P Rate	2P Rate	FF Rate	Monthly Composite	Total Cost	Estimated Annual Savings
NVA Vision Plan - copay option	7/1/2016-6/30/2018	$5.27	$10.55	$19.00	$15.09	$5,433	$3,654
NVA Vision Plan - no copay	7/1/2016-6/30/2018	$7.89	$15.78	$28.41	$22.57	$8,125	$962
Principal Vision Plan	7/1/2016-6/30/2017	$9.16	$17.31	$29.39	$23.74	$8,547	$539
Guardian		declined to quote					
MetLife		declined to quote					

*NVA rates include taxes and fees.
*Principal rates include taxes and fees. Employee & Spouse rates and Employee & Child(ren) rates were provided. Employee & Spouse rates are shown above.

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products represented.

Vision Plan Comparison

Bellaire Public Schools

All Employees

	CURRENT PLAN		CURRENT PLAN		Option 1		Option 2		Option 3	
	Principal and Teacher		Bus Driver, Aide and Secretary							
Name	**VSP 3 Plus**		**VSP 2 Silver**		**NVA Vision Plan - copay option**		**NVA Vision Plan - no copay**		**Principal Vision Plan**	
Rate Period	7/1/2016-6/30/2017		7/1/2016-6/30/2017		7/1/2016-6/30/2018		7/1/2016-6/30/2018		7/1/2016-6/30/2017	
Purchased Plan Features	**Coverage Allowance**		**Coverage Allowance**		**Coverage Allowance**		**Coverage Allowance**		**Coverage Allowance**	
Optometrist Exam	100% once every 12 months		100% after exam copay once every 12 months		100% after exam copay once every 12 months		100% once every 12 months		100% after exam copay once every 12 months	
Ophthalmologist Exam	100% once every 12 months		100% after exam copay once every 12 months		100% after exam copay once every 12 months		100% once every 12 months		100% after exam copay once every 12 months	
Regular Lenses	100% once every 12 months		100% after material copay once every 12 months		100% after material copay once every 12 months		100% once every 12 months		100% after material copay once every 12 months	
Bifocal Lenses	100% once every 12 months		100% after material copay once every 12 months		100% after material copay once every 12 months		100% once every 12 months		100% after material copay once every 12 months	
Trifocal Lenses	100% once every 12 months		100% after material copay once every 12 months		100% after material copay once every 12 months		100% once every 12 months		100% after material copay once every 12 months	
Lentiuclar Lenses	100% once every 12 months		100% after material copay once every 12 months		100% after material copay once every 12 months		100% once every 12 months		100% after material copay once every 12 months	
Frame Allowance	$80.00 allowance once every 12 months		$130.00 allowance once every 12 months		Covered up to $130.00 Retail Allowance once every 12 months (20% discount off remaining balance over $130.00 allowance)		Covered up to $130.00 Retail Allowance once every 12 months (20% discount off remaining balance over $130.00 allowance)		$150.00 allowance for a wide selection of frames once every 12 months (20% off amount over allowance)	
Necessary Contacts	100% once every 12 months		100% after material copay once every 12 months		100% after material copay once every 12 months		100% once every 12 months		100% after material copay once every 12 months	
Cosmetic Contacts	100% ($200.00 allowance for disposable) once every 12 months		$110.00 allowance once every 12 months		Covered up to $110.00 Retail Allowance (15% discount (Conventional) or 10% discount (Disposable) off remaining balance over $110.00 allowance)		Covered up to $200.00 Retail Allowance (15% discount (Conventional) or 10% discount (Disposable) off remaining balance over $200.00 allowance)		$150.00 allowance once every 12 months	
Exam Copay	$0.00		$6.50		$6.50		$0.00		$10.00	
Material Copay	$0.00		$18.00		$18.00		$0.00		$25.00	
Purchased Plan Rates	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**
One Person (1P)	3	$10.02	0	$5.76	3	$5.27	3	$7.89	3	$9.16
Two Person (2P)	5	$21.54	4	$12.38	9	$10.55	9	$15.78	9	$17.31
Family (FF)	17	$32.43	1	$18.64	18	$19.00	18	$28.41	18	$29.39
Total Annual Premium	**25**	**$8,269**	**5**	**$818**	**30**	**$5,433**	**30**	**$8,125**	**30**	**$8,547**
Combined Annual Premium	**$9,087**		**< TOTALS**							
Estimated Cost for Benefit Increase - $					**$10**	**$3,654**	**$3**	**$962**	**$1**	**$539**
Estimated Savings - %						**40%**		**11%**		**6%**

*NVA rates include taxes and fees.

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