Medical Policy # 00125981-0001- 0001 Renewal Date: 11/1/2023	BCN HM	ent Plan O \$500 100% Billed Ages)	BCN HM	wal Plan - O \$500 100% I Billed Ages)		tinum % \$0 Deductible		tinum % \$0 Deductible
Network:	BCI	N НМО	BCI	BCN HMO		НМО	BCN	I НМО
Employee Deductible:	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Single	\$500	N/A	\$500	N/A	\$0	N/A	\$0	N/A
Family	\$1,000	N/A	\$1,000	N/A	\$0	N/A	\$0	N/A
Coinsurance:	<u>In-Network</u>	Out-of-Network	<u>In-Network</u>	Out-of-Network	<u>In-Network</u>	<u>Out-of-Network</u>	<u>In-Network</u>	Out-of-Network
Carrier Coinsurance Liability %	100%	N/A	100%	N/A	90%	N/A	80%	N/A
Coinsurance Max - Single	N/A	N/A	N/A	N/A	\$1,000	N/A	\$1,000	N/A
Coinsurance Max - Family	N/A	N/A	N/A	N/A	\$2,000	N/A	\$2,000	N/A
EE True Out of Pocket Max:	<u>In-Network</u>	Out-of-Network	<u>In-Network</u>	Out-of-Network	<u>In-Network</u>	Out-of-Network	In-Network	Out-of-Network
Single	\$1,500	N/A	\$1,500	N/A	\$5,000	N/A	\$6,600	N/A
Family	\$3,000	N/A	\$3,000	N/A	\$10,000	N/A	\$13,200	N/A
In-Network Employee Copay:								
Office Visit		\$20		\$20	Ş	520		\$25
TeleMedicine Visit		\$20		\$0*	\$	\$0*	:	\$0*
Specialist Visit		\$30		\$30	Ç	30	:	\$35
Urgent Care		\$35	\$35		Ç	35		\$35
Emergency Room	\$150 afte	er Deductible	\$150 after Deductible		\$	150	\$	150
Hospital Admission	0% after	r Deductible	0% after Deductible		10% after Deductible		20% after Deductible	
Imaging	\$150 afte	er Deductible	\$150 afte	er Deductible	\$	150	\$	150
Employee In-Network RX Copay:								
Tier 1 / 1A: Generic	\$4	\$15	\$4	\$15	\$4	\$15	\$4	\$15
Tier 2: Preferred Brand		\$40		\$40		\$40		\$40
Tier 3: Non-Preferred Brand		\$80	<u> </u>	\$80	9	\$80		\$80
Tier 4: Preferred Specialty		00 Maximum)	1	00 Maximum)	· · ·	0 Maximum)	• •	0 Maximum)
Tier 5: Non-Preferred Specialty		00 Maximum)	· · ·	00 Maximum)	· · ·	0 Maximum)		0 Maximum)
Prescription Formulary	Custo	om Select	Custo	om Select	Custo	m Select	Custo	m Select
Plan Provisions:								
Dependent Age		Year Age 26	i	Year Age 26	•	ear Age 26		ear Age 26
Pediatric Dental		Included		Included		ncluded		ncluded
	Elective Abortion Not Included			Included		ncluded		ncluded
Domestic Partner Rider		Included		Included	Not Included		Not Included	
Monthly / Annual Premium	\$25,734.51	\$308,814.12	\$28,311.53	\$339,738.36	\$28,494.07	\$341,928.84	\$27,759.92	\$333,119.04
\$ Change from Current			\$2,577.02	\$30,924.24	\$2,759.56	\$33,114.72	\$2,025.41	\$24,304.92
% Change from Current			1	0.01%	10).72%	7	.87%



Medical Policy # 00125981-0001- 0001 Renewal Date: 11/1/2023	BCN HM	ent Plan O \$500 100% Billed Ages)	BCN HM	wal Plan - O \$500 100% I Billed Ages)		itinum HMO 500		Gold MO 1000
Network:	BCI	N НМО	BCI	BCN HMO		Р НМО	НАГ	НМО
Employee Deductible:	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Single	\$500	N/A	\$500	N/A	\$500	N/A	\$1,000	N/A
Family	\$1,000	N/A	\$1,000	N/A	\$1,000	N/A	\$2,000	N/A
Coinsurance:	<u>In-Network</u>	Out-of-Network	<u>In-Network</u>	Out-of-Network	<u>In-Network</u>	<u>Out-of-Network</u>	<u>In-Network</u>	Out-of-Network
Carrier Coinsurance Liability %	100%	N/A	100%	N/A	100%	N/A	80%	N/A
Coinsurance Max - Single	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Coinsurance Max - Family	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
EE True Out of Pocket Max:	<u>In-Network</u>	Out-of-Network	<u>In-Network</u>	Out-of-Network	<u>In-Network</u>	Out-of-Network	<u>In-Network</u>	Out-of-Network
Single	\$1,500	N/A	\$1,500	N/A	\$2,000	N/A	\$6,500	N/A
Family	\$3,000	N/A	\$3,000	N/A	\$4,000	N/A	\$13,000	N/A
In-Network Employee Copay:								
Office Visit		\$20		\$20		\$20		\$35
TeleMedicine Visit		\$20		\$0*	Ş	60**	\$	60**
Specialist Visit		\$30		\$30		\$40	:	\$60
Urgent Care		\$35	\$35			\$65	:	\$65
Emergency Room	\$150 afte	er Deductible	\$150 after Deductible		\$	200	\$	300
Hospital Admission	0% after	r Deductible	0% after Deductible		0% after Deductible		20% after Deductible	
Imaging	\$150 afte	er Deductible	\$150 afte	er Deductible	0% after	Deductible	\$150 Cop	oay per Test
Employee In-Network RX Copay:								
Tier 1 / 1A: Generic	\$4	\$15	\$4	\$15	\$5	\$15	\$5	\$25
Tier 2: Preferred Brand		\$40		\$40		\$30		\$40
Tier 3: Non-Preferred Brand		\$80	<u> </u>	\$80		\$60		\$80
Tier 4: Preferred Specialty	• •	00 Maximum)	1	00 Maximum)	• • • • • • • • • • • • • • • • • • • •	0 Maximum)	**	O Maximum)
Tier 5: Non-Preferred Specialty		00 Maximum)	· · ·	00 Maximum)	• • • • • • • • • • • • • • • • • • • •	0 Maximum)	**	O Maximum)
Prescription Formulary	Custo	om Select	Custo	om Select		N/A		N/A
Plan Provisions:	- I ()	, , , , , ,	- 1 6		- 1 ()	, , ,,		
Dependent Age		Year Age 26	i	Year Age 26	•	/ear Age 26		ear Age 26
Pediatric Dental Elective Abortion		Included Included		Included Included		Included ncluded		ncluded ncluded
Domestic Partner Rider		Included Included		Included Included		nciuaea Included		nciuded ncluded
Monthly / Annual Premium	\$25,734.51	\$308,814.12	\$28,311.53	\$339,738.36	\$30,623.31	\$367,479.72	\$22,884.95	\$274,619.40
\$ Change from Current			\$2,577.02	\$30,924.24 0.01%	\$4,888.80	\$58,665.60 9.00%	(\$2,849.56)	(\$34,194.72) 1.07%
% Change from Current			1	U.U1%	1	9.00%	-1	1.0/%



00125981-0001- Medical Policy # 0001 Renewal Date: 11/1/2023	BCN HM	ent Plan O \$500 100% Billed Ages)	BCN HM	wal Plan - O \$500 100% I Billed Ages)		tinum 1 HMO 250 100%		tinum h HMO 250 90%
Network:	BCI	и нмо	BCI	BCN HMO		lealth HMO	Priority H	lealth HMO
Employee Deductible:	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Single	\$500	N/A	\$500	N/A	\$250	N/A	\$250	N/A
Family	\$1,000	N/A	\$1,000	N/A	\$500	N/A	\$500	N/A
Coinsurance:	<u>In-Network</u>	Out-of-Network	<u>In-Network</u>	Out-of-Network	<u>In-Network</u>	Out-of-Network	<u>In-Network</u>	Out-of-Network
Carrier Coinsurance Liability %	100%	N/A	100%	N/A	100%	N/A	90%	N/A
Coinsurance Max - Single	N/A	N/A	N/A	N/A	N/A	N/A	\$2,000	N/A
Coinsurance Max - Family	N/A	N/A	N/A	N/A	N/A	N/A	\$4,000	N/A
EE True Out of Pocket Max:	<u>In-Network</u>	Out-of-Network	<u>In-Network</u>	Out-of-Network	<u>In-Network</u>	Out-of-Network	<u>In-Network</u>	Out-of-Network
Single	\$1,500	N/A	\$1,500	N/A	\$5,000	N/A	\$5,000	N/A
Family	\$3,000	N/A	\$3,000	N/A	\$10,000	N/A	\$10,000	N/A
In-Network Employee Copay:								
Office Visit		\$20		\$20	\$	\$15	9	\$20
TeleMedicine Visit		\$20		\$0*	\$	\$10	9	\$10
Specialist Visit		\$30		\$30	\$	\$35	!	35
Urgent Care		\$35	\$35		,	\$75		\$75
Emergency Room	\$150 afte	er Deductible	\$150 after Deductible		\$250 after Deductible		\$250 afte	r Deductible
Hospital Admission	0% after	r Deductible	0% after Deductible		100% after Deductible		10% after	r Deductible
Imaging	\$150 afte	er Deductible	\$150 afte	er Deductible	\$150 afte	r Deductible	\$150 after Deductible	
Employee In-Network RX Copay:								
Tier 1 / 1A: Generic	\$4	\$15	\$4	\$15	\$5	\$10	\$5	\$15
Tier 2: Preferred Brand		\$40		\$40	'	\$40		\$40
Tier 3: Non-Preferred Brand		\$80	•	\$80		\$80		\$80
Tier 4: Preferred Specialty	**	00 Maximum)	· · ·	00 Maximum)		0 Maximum)	**	0 Maximum)
Tier 5: Non-Preferred Specialty	· · · · · · · · · · · · · · · · · · ·	0 Maximum)	i	00 Maximum)	**	0 Maximum)	· ·	0 Maximum)
Prescription Formulary	Custo	om Select	Custo	om Select	ľ	N/A	ľ	N/A
Plan Provisions:	F ()	/ A 26	E ()	/ A 26	F l . ()	/ A 26	E - 1 - C \	/ A 2C
Dependent Age		Year Age 26	•	Year Age 26		ear Age 26		ear Age 26
Pediatric Dental Elective Abortion		Included		Included Included		ncluded ncluded		ncluded ncluded
Domestic Partner Rider				Included Included				ncluded
Monthly / Annual Premium	\$25,734.51	\$308,814.12	\$28,311.53	\$339,738.36	Not Included		\$26,318.73	\$315,824.76
	7 25,/54.51	3300,614.12			\$26,925.81	\$323,109.72		· ·
\$ Change from Current % Change from Current			\$2,577.02 1	\$30,924.24 0.01%	\$1,191.30 4	\$14,295.60 .63%	\$584.22 2	\$7,010.64 .27%



Medical Policy # 007005509-0000 Renewal Date: 11/1/2023	BCBSM Simpl (Current	ent Plan y Blue PPO \$250 Billed Ages)	BCBSM Simp (Renewa	Renewal Plan - BCBSM Simply Blue PPO \$250 (Renewal Billed Ages)		Gold ly Blue PPO \$500	Gold BCBSM Simply Blue PPO \$1000	
Network:	Blue Cross Blue	Shield of Michigan	Blue Cross Blue	Shield of Michigan	Blue Cross Blue	Shield of Michigan	Blue Cross Blue	Shield of Michigan
Employee Deductible:	In-Network	Out-of-Network	<u>In-Network</u>	Out-of-Network	<u>In-Network</u>	Out-of-Network	<u>In-Network</u>	Out-of-Network
Single Family	\$250 \$500	\$500 \$1,000	\$250 \$500	\$500 \$1,000	\$500 \$1,000	\$1,000 \$2,000	\$1,000 \$2,000	\$2,000 \$4,000
Coinsurance:	<u>In-Network</u>	Out-of-Network	<u>In-Network</u>	Out-of-Network	<u>In-Network</u>	<u>Out-of-Network</u>	<u>In-Network</u>	Out-of-Network
Carrier Coinsurance Liability %	80%	60%	80%	60%	70%	50%	80%	60%
Coinsurance Max - Single	\$1,000	\$2,000	\$1,000	\$2,000	\$5,000	\$10,000	\$5,000	\$10,000
Coinsurance Max - Family	\$2,000	\$4,000	\$2,000	\$4,000	\$10,000	\$20,000	\$10,000	\$20,000
EE True Out of Pocket Max:	In-Network	Out-of-Network	<u>In-Network</u>	Out-of-Network	<u>In-Network</u>	Out-of-Network	<u>In-Network</u>	Out-of-Network
Single	\$6,600	\$13,200	\$6,600	\$13,200	\$8,150 \$16,300		\$8,150	\$16,300
Family	\$13,200 \$26,400		\$13,200	\$26,400	\$16,300	\$32,600	\$16,300	\$32,600
In-Network Employee Copay:								
Office Visit	\$20			\$20		\$30	:	\$30
TeleMedicine Visit	Ç	\$20	Covered 100%	By BCBSM Vendor	Covered 100%	By BCBSM Vendor	Covered 100%	By BCBSM Vendor
Specialist Visit	Ç	\$40		\$40		\$50	!	\$50
Urgent Care	9	\$60		\$60		\$60	:	\$60
Emergency Room	\$	150	\$150		\$	250	\$	250
Hospital Admission	20% afte	r Deductible	20% after Deductible		30% after Deductible		20% after Deductible	
Imaging	20% afte	r Deductible	20% after Deductible		30% after Deductible		20% after Deductible	
Employee In-Network RX Copay:								
Tier 1 / 1A: Generic		\$10		\$10	:	\$20	\$20	
Tier 2: Preferred Brand		\$40		\$40		\$60	\$60	
Tier 3: Non-Preferred Brand		\$80		\$80	:	100	•	100
Tier 4: Preferred Specialty	•	0 Maximum)	•	0 Maximum)	•	0 Maximum)	•	0 Maximum)
Tier 5: Non-Preferred Specialty	•	0 Maximum)	•	0 Maximum)		0 Maximum)	,	0 Maximum)
Prescription Formulary	Custo	m Select	Custo	m Select	Custo	m Select	Custo	m Select
Plan Provisions:								
Dependent Age		ear Age 26		/ear Age 26	<u> </u>	'ear Age 26		'ear Age 26
Pediatric Dental		on Dental		Included		ncluded		ncluded
Elective Abortion	Not Included			Included		ncluded		ncluded
Domestic Partner Rider		ncluded		Included	Not Included			ncluded
Monthly / Annual Premium	\$2,719.11	\$32,629.32	\$2,871.53	\$34,458.36	\$2,375.81	\$28,509.72	\$2,354.15	\$28,249.80
\$ Change from Current % Change from Current			\$ 152.42 5	\$1,829.04 5.61%	(\$343.30) -1	(\$4,119.60) 2.63%	(\$364.96) -1	(\$4,379.52) 3.42%



Medical Policy # 007005509-0000 Renewal Date: 11/1/2023	BCBSM Simp	ent Plan ly Blue PPO \$250 Billed Ages)	BCBSM Simp	val Plan - ly Blue PPO \$250 l Billed Ages)		num \$0 P PPO		um \$250 P PPO
Network:	Blue Cross Blue	Shield of Michigan	Blue Cross Blue	Shield of Michigan	HA	P PPO	HA	IP PPO
Employee Deductible:	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Single	\$250	\$500	\$250	\$500	\$0	\$3,000	\$250	\$3,000
Family	\$500	\$1,000	\$500	\$1,000	\$0	\$6,000	\$500	\$6,000
Coinsurance:	<u>In-Network</u>	Out-of-Network	<u>In-Network</u>	Out-of-Network	<u>In-Network</u>	<u>Out-of-Network</u>	<u>In-Network</u>	Out-of-Network
Carrier Coinsurance Liability %	80%	60%	80%	60%	100%	50%	100%	50%
Coinsurance Max - Single	\$1,000	\$2,000	\$1,000	\$2,000	N/A	N/A	N/A	N/A
Coinsurance Max - Family	\$2,000	\$4,000	\$2,000	\$4,000	N/A	N/A	N/A	N/A
EE True Out of Pocket Max:	<u>In-Network</u>	Out-of-Network	<u>In-Network</u>	Out-of-Network	<u>In-Network</u>	Out-of-Network	<u>In-Network</u>	Out-of-Network
Single	\$6,600	\$13,200	\$6,600	\$13,200	\$1,500	\$20,000	\$1,500	\$20,000
Family	\$13,200	\$26,400	\$26,400 \$13,200 \$26,400		\$3,000	\$40,000	\$3,000	\$40,000
In-Network Employee Copay:								
Office Visit		\$20		\$20	\$20			\$20
TeleMedicine Visit		\$20	Covered 100%	By BCBSM Vendor	\$	0**	Ş	0**
Specialist Visit		\$40		\$40	Ç	\$40		\$40
Urgent Care		\$60		\$60	\$	65		\$65
Emergency Room	9	\$150	\$150		\$	200	Ş	200
Hospital Admission	20% afte	er Deductible	20% after Deductible		0% after Deductible		0% after Deductible	
Imaging	20% afte	er Deductible	20% afte	r Deductible	0% after	Deductible	0% after Deductible	
Employee In-Network RX Copay:								
Tier 1 / 1A: Generic		\$10		\$10	\$5	\$20	\$5	\$15
Tier 2: Preferred Brand		\$40		\$40	\$30			\$30
Tier 3: Non-Preferred Brand		\$80		\$80		660		\$60
Tier 4: Preferred Specialty	**	50 Maximum)	٠.	0 Maximum)	:) Maximum)	• • • • • • • • • • • • • • • • • • • •	0 Maximum)
Tier 5: Non-Preferred Specialty	•	00 Maximum)	•	0 Maximum)	:) Maximum)	•	0 Maximum)
Prescription Formulary	Custo	om Select	Custo	m Select	1	I/A		N/A
Plan Provisions:	_ ,				_ ,			
Dependent Age		Year Age 26		/ear Age 26	1	ear Age 26		/ear Age 26
Pediatric Dental		d on Dental		Included		ncluded		Included
Elective Abortion		Included		Included	1	ncluded		ncluded
Domestic Partner Rider		Included		Included	Not Included			Included
Monthly / Annual Premium	\$2,719.11	\$32,629.32	\$2,871.53	\$34,458.36	\$3,094.66	\$37,135.92	\$2,988.48	\$35,861.76
\$ Change from Current			\$152.42	\$1,829.04	\$375.55	\$4,506.60	\$269.37	\$3,232.44
% Change from Current			5	.61%	13	3.81%	9	.91%



Medical Policy # 007005509-0000 Renewal Date: 11/1/2023	BCBSM Simp	ent Plan ly Blue PPO \$250 : Billed Ages)	BCBSM Simp	wal Plan - ly Blue PPO \$250 l Billed Ages)		atinum th PPO 250 100%		tinum th PPO 250 90%
Network:	Blue Cross Blue	Shield of Michigan	Blue Cross Blue	Shield of Michigan	Priority	Health PPO	Priority	Health PPO
Employee Deductible:	In-Network	Out-of-Network	<u>In-Network</u>	Out-of-Network	<u>In-Network</u>	Out-of-Network	In-Network	Out-of-Network
Single Family	\$250 \$500	\$500 \$1,000	\$250 \$500	\$500 \$1,000	\$250 \$500	\$500 \$1,000	\$250 \$500	\$500 \$1,000
Coinsurance:	<u>In-Network</u>	Out-of-Network	<u>In-Network</u>	Out-of-Network	<u>In-Network</u>	Out-of-Network	<u>In-Network</u>	Out-of-Network
Carrier Coinsurance Liability %	80%	60%	80%	60%	100%	70%	90%	70%
Coinsurance Max - Single	\$1,000	\$2,000	\$1,000	\$2,000	N/A	N/A	\$2,000	\$4,000
Coinsurance Max - Family	\$2,000	\$4,000	\$2,000	\$4,000	N/A	N/A	\$4,000	\$8,000
EE True Out of Pocket Max:	<u>In-Network</u>	Out-of-Network	<u>In-Network</u>	Out-of-Network	<u>In-Network</u>	Out-of-Network	<u>In-Network</u>	Out-of-Network
Single	\$6,600	\$13,200	\$6,600	\$13,200	\$5,000 \$10,000		\$5,000	\$10,000
Family	\$13,200	\$26,400	\$13,200	\$26,400	\$10,000	\$20,000	\$10,000	\$20,000
In-Network Employee Copay:								
Office Visit		\$20		\$20		\$15	:	\$20
TeleMedicine Visit		\$20	Covered 100%	By BCBSM Vendor		\$10		\$10
Specialist Visit		\$40		\$40		\$35	:	\$35
Urgent Care		\$60		\$60		\$75	:	\$75
Emergency Room	•	\$150	\$150		\$	\$100	\$250 afte	r Deductible
Hospital Admission	20% afte	er Deductible	20% after Deductible		0% after Deductible		10% after Deductible	
Imaging	20% afte	er Deductible	20% afte	r Deductible	\$150 afte	er Deductible	\$150 after Deductible	
Employee In-Network RX Copay:								
Tier 1 / 1A: Generic		\$10		\$10	\$5	\$10	\$5	\$15
Tier 2: Preferred Brand		\$40		\$40	\$40			\$40
Tier 3: Non-Preferred Brand		\$80		\$80	İ	\$80		\$80
Tier 4: Preferred Specialty	٠.	50 Maximum)	''	0 Maximum)	**	0 Maximum)	**	0 Maximum)
Tier 5: Non-Preferred Specialty	٠.	00 Maximum)	` '	0 Maximum)	• • • • • • • • • • • • • • • • • • • •	0 Maximum)	••	0 Maximum)
Prescription Formulary	Custo	om Select	Custo	om Select		N/A		N/A
Plan Provisions:	F J - £ \	V A 2C	FI £ \	/ A 2C	F1 - £ \	/ A 2C	FI63	/ A 2C
Dependent Age		Year Age 26		/ear Age 26	1	Year Age 26		ear Age 26
Pediatric Dental Elective Abortion		d on Dental Included		Included Included	İ	Included Included		ncluded ncluded
Domestic Partner Rider		Included		Included Included	1	Included		
Monthly / Annual Premium	\$2,719.11	\$32,629.32	\$2,871.53	\$34,458.36	\$2,988.83	\$35,865.96	Not Included \$2,929.14 \$35,149.	
\$ Change from Current	72)713111	492,023132	\$152.42	\$1,829.04	\$269.72	\$3,236.64	\$210.03	\$2,520.36
% Change from Current			Ę	5.61%	g	9.92%	7	.72%



Dental Policy # 4544 Renewal Date: 11/1/2023 Plan Provisions:		Current Delta Dental	l		Renewal Delta Dental		Guardian		
Train Free Stories	<u>Delta PPO</u>	<u>Premier</u>	Non-Participating	<u>Delta PPO</u>	<u>Premier</u>	Non-Participating	<u>In-Network</u>	Out-of-Network	
Network / UCR	Delt	a USA	Non-Par Fee	Delt	a USA	Non-Par Fee	DentalGuard Preferred	90th	
Single Deductible Two Person / Family Deductible Calendar Year Max Per Person diatric Dental EHB (Small Group Only) Maximum Rollover Preventative Advantage	\$50 \$150	\$50 \$150 \$1,500 Included in Rat Not Included Included	:	\$50 \$150	\$50 \$150 \$1,500 Included in Rat Not Included Included		Include Inc	\$50 \$150 1,500 Id in Rates Iluded	
Type I - Preventative Services:									
Cleanings (Oral Prophylaxis) Frequency on Routine Cleanings Exams X-Rays	100% 2x 100% 100%	100% 2x 100% 100%	100% 2x 100% 100%	100% 2x 100% 100%	100% 2x 100% 100%	100% 2x 100% 100%	100% 2x 100% 100%	100% 2x 100% 100%	
Fluoride Treatments	100%	100%	100%	100%	100%	100%	100%	100%	
Type II - Basic Services:									
Fillings Oral Surgery Periodontics Endodontics	80% 80% 80% 80%	80% 80% 80% 80%	80% 80% 80% 80%	80% 80% 80% 80%	80% 80% 80% 80%	80% 80% 80% 80%	80% 80% 80% 80%	80% 80% 80% 80%	
Type III - Major Services:	3373	33,3	00,0	5575	3373	30,1	55,5	30,1	
Crowns / Onlays Bridges / Dentures Implants	50% 50% 50%	50% 50% 50%	50% 50% 50%	50% 50% 50%	50% 50% 50%	50% 50% 50%	50% 50% 50%	50% 50% 50%	
Type IV - Child Orthodontics:									
Orthodontics Child Ortho Lifetime Max	N/A	N/A N/A	N/A	N/A	N/A N/A	N/A	N/A I	N/A N/A	
Additional Details: Participation Requirement Dependent Age Headcounts / Rates:		of All Eligible En o End of Year Ag			of All Eligible En o End of Year Ag	· · ·	86% of Eligible To End of Year Age 26		
Single 26 EE & Spouse 6 EE & Child 2 EE & Children 1 Family 3 Total Enrolled 38		\$49.96 \$91.93 \$91.93 \$154.06 \$154.06		\$51.46 \$94.69 \$94.69 \$158.68 \$158.68			\$51.96 \$95.61 \$95.61 \$160.22 \$160.22		
Rate Guarantee Duration:	40 CT0 01		404 007 40	40 700	12 Months	400 700 10		/onths	
Monthly / Annual Premium \$ Change from Current % Change from Current	\$2,650.64		\$31,807.68	\$2,730.20 \$79.56	3.00%	\$32,762.40 \$954.72	\$2,756.72 \$106.08 4	\$33,080.64 \$1,272.96 .00%	



•	544 1/2023		Current Delta Dental			Renewal Delta Dental			Delta Dental	
Plan Provisions:		- h			- 1			- 1:		
		<u>Delta PPO</u>	<u>Premier</u>	Non-Participating	<u>Delta PPO</u>	<u>Premier</u>	Non-Participating	<u>Delta PPO</u>	<u>Premier</u>	Non-Participatin
Netw	ork / UCR	Delta	USA	Non-Par Fee	Delta	USA	Non-Par Fee	Delta	USA	Non-Par Fee
Single D	eductible	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50
Two Person / Family De	1	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150
Calendar Year Max P			\$1,500 Included in Rate			\$1,500 Included in Rat	0.0		\$2,000 Included in Rat	••
liatric Dental EHB (Small Gro Maximum			Not Included	25		Not Included	1		Not Included	es
Preventative A	1		Included			Included			Included	
Type I - Preventative Service			meiaaca			meraded			meradea	
Cleanings (Oral Pro		100%	100%	100%	100%	100%	100%	100%	100%	100%
Frequency on Routine (2x	2x	2x	2x	100% 2x	2x	100% 2x	100% 2x	2x
rrequency on Routine C	Exams	100%	100%	100%	100%	100%	100%	100%	100%	100%
	X-Rays	100%	100%	100%	100%	100%	100%	100%	100%	100%
Fluoride Tr		100%	100%	100%	100%	100%	100%	100%	100%	100%
Type II - Basic Services:										
	Fillings	80%	80%	80%	80%	80%	80%	80%	80%	80%
Ora	al Surgery	80%	80%	80%	80%	80%	80%	80%	80%	80%
	riodontics	80%	80%	80%	80%	80%	80%	80%	80%	80%
End	dodontics	80%	80%	80%	80%	80%	80%	80%	80%	80%
Type III - Major Services:										
Crowns	s / Onlays	50%	50%	50%	50%	50%	50%	50%	50%	50%
	Dentures	50%	50%	50%	50%	50%	50%	50%	50%	50%
-	Implants	50%	50%	50%	50%	50%	50%	50%	50%	50%
Type IV - Child Orthodontic	cs:									
Orth	hodontics	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child Ortho Lifet	time Max	,	N/A	,	,	N/A	,	•	N/A	•
Additional Details:										
Participation Reg	uirement	75% o	f All Eligible Em	plovees	75% o	f All Eligible Em	nplovees	75% c	of All Eligible Em	plovees
·	ndent Age		End of Year Ag			End of Year Ag	· · ·		End of Year Ag	
Headcounts / Rates:			_			_			_	
	26		\$49.96			\$51.46			\$52.79	
· ·	6		\$91.93			\$94.69			\$97.15	
•	2		\$91.93			\$94.69			\$97.15	
EE & Children	1		\$154.06			\$158.68			\$162.81	
Family	<u>3</u>		\$154.06			\$158.68			\$162.81	
Total Enrolled	38									
Rate Guarantee	Duration:					12 Months			12 Months	
Monthly / Annual	Premium	\$2,650.64		\$31,807.68	\$2,730.20		\$32,762.40	\$2,800.98		\$33,611.76
\$ Change fron	n Current				\$79.56		\$954.72	\$150.34		\$1,804.08
% Change fron	n Current					3.00%			5.67%	



Vision Policy # Renewal Date: Plan Co-Payment	007005509-0000 & 00125981-0001- 0001 45231		ent Plan CBSM	Renewal Plan BCBSM		ι	MUNI	Delta	Delta Vision	
		<u>In-Network</u>	Out-of-Network	In-Network	<u>Out-of-Network</u>	<u>In-Network</u>	Out-of-Network	<u>In-Network</u>	Out-of-Network	
	Examinations Materials	\$5 \$10	Up to \$34	\$5 \$10	Up to \$34	\$10 \$10	Up to \$40	\$10 \$25	Up to \$45	
Frequency (# of I	Months):	Onc	e Every:	One	ce Every:	Once Every:		Once Every:		
	Examinations Lenses Frames		24 24 24		24 24 24	12 12 24		12 12 24		
	Contact Lenses		24		24		12		12	
Plan Allowances		U	lp to:		Up to:	ι	Jp to:	U	p to:	
Medically Plan Provisions: Contact Lense	Bifocal Lenses Bifocal Lenses Trifocal Lenses Lenticular Lenses Frames Necessary Contacts Elective Contacts Network es in Lieu of Frames Frame Discount Lens Discount Dependent Age	To End o	Pre-Determ. Amount Pre-Determ. Amount Pre-Determ. Amount Pre-Determ. Amount \$38.25 \$210 \$100 P Choice No No No f Year Age 26 3CBSM Medical	To End o	Pre-Determ. Amount Pre-Determ. Amount Pre-Determ. Amount Pre-Determ. Amount \$38.25 \$210 \$100 P Choice No No No Of Year Age 26 BCBSM Medical	To End o	\$30 \$50 \$70 \$70 \$91 \$210 \$130 Hed Insight Yes Yes Yes Yes Ordal Eligible	To End of	\$30 \$50 \$60 \$100 \$70 \$210 \$105 Choice Yes Yes Yes Year Age 26 Sold w/ Delta Dental	
Headcounts / Ra	tes:									
Single EE & Spouse EE & Child EE & Children Family Total Enrolled	27 2 2 1 3 35	Age Banded Age Banded Age Banded Age Banded Age Banded		Age Banded Age Banded Age Banded Age Banded Age Banded		\$5.17 \$10.33 \$11.31 \$11.31 \$17.77		\$5.60 \$11.20 \$11.99 \$11.99 \$19.16		
	uarantee Duration	4454-00-	44.040.44		Months	48 Months			Months	
_	/ Annual Premium	\$161.93	\$1,943.16	\$166.95	\$2,003.40	\$247.49	\$2,969.88	\$267.05	\$3,204.60	
\$ Change from Current % Change from Current				\$5.02	\$60.24 3.10%	\$85.56 5	\$1,026.72 2.84%	\$105.12 64	\$1,261.44 I.92%	



	07005509-0000 00125981-0001 0001 45231		rent Plan CBSM		ewal Plan 3CBSM	UNUM		Delta Vision		
		In-Network	Out-of-Network	<u>In-Network</u>	Out-of-Network	<u>In-Network</u>	Out-of-Network	<u>In-Network</u>	Out-of-Network	
	Examinations Materials	\$5 \$10	Up to \$34	\$5 \$10	Up to \$34	\$10 \$10	Up to \$40	\$10 \$25	Up to \$45	
Frequency (# of Mon	nths):	Onc	e Every:	One	ce Every:	Ond	e Every:	Once	Every:	
	Examinations		24		24		12		12	
	Lenses		24		24		12		12	
	Frames		24		24		24		24	
	Contact Lenses		24		24		12		12	
Plan Allowances:			Jp to:		Up to:		Jp to:	Up to:		
Singl	le Vision Lenses	Paid-in-Full ⁴	Pre-Determ. Amount	Paid-in-Full ⁴	Pre-Determ. Amount	Paid-in-Full ⁴	\$30	Paid-in-Full ⁴	\$30	
	Bifocal Lenses	Paid-in-Full ⁴	Pre-Determ. Amount	Paid-in-Full ⁴	Pre-Determ. Amount	Paid-in-Full ⁴	\$50	Paid-in-Full ⁴	\$50	
	Trifocal Lenses	Paid-in-Full ⁴	Pre-Determ. Amount	Paid-in-Full ⁴	Pre-Determ. Amount	Paid-in-Full ⁴	\$70	Paid-in-Full ⁴	\$60	
Le	enticular Lenses	Paid-in-Full ⁴	Pre-Determ. Amount	Paid-in-Full ⁴	Pre-Determ. Amount	Paid-in-Full ⁴	\$70	Paid-in-Full ⁴	\$100	
	Frames	\$130	\$38.25	\$130	\$38.25	\$150	\$91	\$150	\$70	
	essary Contacts lective Contacts	Paid-in-Full ⁴	\$210 \$100	Paid-in-Full ⁴	\$210 \$100	Paid-in-Full ⁴	\$210	Paid-in-Full ⁴	\$210	
Plan Provisions:	lective Contacts	\$130	\$100	\$130	\$100	\$150	\$150	\$150	\$105	
Plan Provisions:										
	Network	VSP Choice		VSP Choice		EyeMed Insight		VSP Choice		
Contact Lenses in			No		No	Yes		Yes		
i	Frame Discount		No	No		Yes		Yes		
,	Lens Discount	To End o	No of Year Age 26	No		Yes		Yes		
	Dependent Age on Requirement		BCBSM Medical	To End of Year Age 26 Sold with BCBSM Medical		To End of Year Age 26 85% of Total Eligible		To End of Year Age 26 Min. 2 Enrolled - Sold w/ Delta Dental		
Headcounts / Rates:		Join With	Deboiti Medical	3014 11111	DODOW Wicarda	0370 01	Total Eligible	Willia 2 Ellioned	Join Wy Delta Delital	
Single	27	Δσε	Banded	Δσ	Banded		\$5.60	Ġ	5.88	
EE & Spouse	2	•	Banded	•	Banded Banded		11.21		11.76	
EE & Child	2	_	Banded	_	e Banded		12.21	•	12.59	
EE & Children			Age	e Banded	Ş	12.21	\$:	12.59		
Family			Age	e Banded	\$	19.20	\$2	20.12		
Total Enrolled	35									
Rate Guara	antee Duration			12	Months	48	Months	12 N	Months	
Monthly / A	nnual Premium	\$161.93	\$1,943.16	\$166.95	\$2,003.40	\$267.85	\$3,214.20	\$280.41	\$3,364.92	
	e from Current			\$5.02	\$60.24	\$105.92	\$1,271.04	\$118.48	\$1,421.76	
% Change from Current					3.10%	6	5.41%	73	3.17%	

