Medical Policy # *00125981-0001-0001* *Renewal Date:* *11/1/2023*	Current Plan BCN HMO $500 100% (Current Billed Ages)		Renewal Plan - BCN HMO $500 100% (Renewal Billed Ages)		Platinum BCN HMO 90% $0 Deductible		Platinum BCN HMO 80% $0 Deductible	
Network:	**BCN HMO**		**BCN HMO**		**BCN HMO**		**BCN 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	**$0**	N/A	**$0**	N/A
Family	$1,000	N/A	$1,000	N/A	**$0**	N/A	**$0**	N/A
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**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:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**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		$20		**$25**	
TeleMedicine Visit	$20		**$0***		**$0***		**$0***	
Specialist Visit	$30		$30		$30		**$35**	
Urgent Care	$35		$35		$35		$35	
Emergency Room	$150 after Deductible		$150 after Deductible		**$150**		**$150**	
Hospital Admission	0% after Deductible		0% after Deductible		**10% after Deductible**		**20% after Deductible**	
Imaging	$150 after Deductible		$150 after 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		$80		$80		$80	
Tier 4: Preferred Specialty	20% ($200 Maximum)		20% ($200 Maximum)		20% ($200 Maximum)		20% ($200 Maximum)	
Tier 5: Non-Preferred Specialty	20% ($300 Maximum)		20% ($300 Maximum)		20% ($300 Maximum)		20% ($300 Maximum)	
Prescription Formulary	**Custom Select**		**Custom Select**		**Custom Select**		**Custom Select**	
Plan Provisions:								
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Not Included		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not 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			**10.01%**		**10.72%**		**7.87%**	

Medical Policy #	*00125981-0001-0001*	Current Plan BCN HMO $500 100% (Current Billed Ages)		Renewal Plan - BCN HMO $500 100% (Renewal Billed Ages)		Platinum HAP HMO 500		Gold HAP HMO 1000	
Renewal Date:	*11/1/2023*								
Network:		**BCN HMO**		**BCN HMO**		**HAP HMO**		**HAP 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	$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:		**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**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:		**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**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***		**$0****		**$0****	
Specialist Visit		$30		$30		**$40**		**$60**	
Urgent Care		$35		$35		**$65**		**$65**	
Emergency Room		$150 after Deductible		$150 after Deductible		**$200**		**$300**	
Hospital Admission		0% after Deductible		0% after Deductible		0% after Deductible		**20% after Deductible**	
Imaging		$150 after Deductible		$150 after Deductible		**0% after Deductible**		**$150 Copay 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		$80		**$60**		$80	
Tier 4: Preferred Specialty		20% ($200 Maximum)		20% ($200 Maximum)		**20% ($200 Maximum)**		**20% ($200 Maximum)**	
Tier 5: Non-Preferred Specialty		20% ($300 Maximum)		20% ($300 Maximum)		**50% ($500 Maximum)**		**50% ($500 Maximum)**	
Prescription Formulary		**Custom Select**		**Custom Select**		**N/A**		**N/A**	
Plan Provisions:									
Dependent Age		End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental		Not Included		Not Included		Not Included		Not Included	
Elective Abortion		Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider		Not Included		Not Included		Not Included		Not Included	
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**	**$4,888.80**	**$58,665.60**	**($2,849.56)**	**($34,194.72)**
% Change from Current				**10.01%**		**19.00%**		**-11.07%**	

Medical Policy #	*00125981-0001-0001*	Current Plan BCN HMO $500 100% (Current Billed Ages)		Renewal Plan - BCN HMO $500 100% (Renewal Billed Ages)		Platinum Priority Health HMO 250 100%		Platinum Priority Health HMO 250 90%	
Renewal Date:	*11/1/2023*								
Network:		**BCN HMO**		**BCN HMO**		**Priority Health HMO**		**Priority Health 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:		**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**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:		**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**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**		$20	
TeleMedicine Visit		$20		**$0***		**$10**		**$10**	
Specialist Visit		$30		$30		**$35**		**$35**	
Urgent Care		$35		$35		**$75**		**$75**	
Emergency Room		$150 after Deductible		$150 after Deductible		**$250 after Deductible**		**$250 after Deductible**	
Hospital Admission		0% after Deductible		0% after Deductible		**100% after Deductible**		**10% after Deductible**	
Imaging		$150 after Deductible		$150 after Deductible		$150 after 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		20% ($200 Maximum)		20% ($200 Maximum)		20% ($200 Maximum)		20% ($200 Maximum)	
Tier 5: Non-Preferred Specialty		20% ($300 Maximum)		20% ($300 Maximum)		20% ($300 Maximum)		20% ($300 Maximum)	
Prescription Formulary		**Custom Select**		**Custom Select**		**N/A**		**N/A**	
Plan Provisions:									
Dependent Age		End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental		Not Included		Not Included		Not Included		Not Included	
Elective Abortion		Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider		Not Included		Not Included		Not Included		Not Included	
Monthly / Annual Premium		**$25,734.51**	**$308,814.12**	**$28,311.53**	**$339,738.36**	$26,925.81	$323,109.72	$26,318.73	$315,824.76
$ Change from Current				**$2,577.02**	**$30,924.24**	**$1,191.30**	**$14,295.60**	**$584.22**	**$7,010.64**
% Change from Current				**10.01%**		**4.63%**		**2.27%**	

Medical Policy # *007005509-0000* *Renewal Date:* *11/1/2023*	Current Plan BCBSM Simply Blue PPO $250 (Current Billed Ages)		Renewal Plan - BCBSM Simply Blue PPO $250 (Renewal Billed Ages)		Gold BCBSM Simply 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**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Single	$250	$500	$250	$500	**$500**	**$1,000**	**$1,000**	**$2,000**
Family	$500	$1,000	$500	$1,000	**$1,000**	**$2,000**	**$2,000**	**$4,000**
Coinsurance:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**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**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**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	$20		**Covered 100% By BCBSM Vendor**		**Covered 100% By BCBSM Vendor**		**Covered 100% By BCBSM Vendor**	
Specialist Visit	$40		$40		**$50**		**$50**	
Urgent Care	$60		$60		$60		$60	
Emergency Room	$150		$150		**$250**		**$250**	
Hospital Admission	20% after Deductible		20% after Deductible		**30% after Deductible**		20% after Deductible	
Imaging	20% after 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	15% ($150 Maximum)		15% ($150 Maximum)		**20% ($200 Maximum)**		**20% ($200 Maximum)**	
Tier 5: Non-Preferred Specialty	25% ($300 Maximum)		25% ($300 Maximum)		25% ($300 Maximum)		25% ($300 Maximum)	
Prescription Formulary	**Custom Select**		**Custom Select**		**Custom Select**		**Custom Select**	
Plan Provisions:								
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Covered on Dental		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
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			**$152.42**	**$1,829.04**	**($343.30)**	**($4,119.60)**	**($364.96)**	**($4,379.52)**
% Change from Current			**5.61%**		**-12.63%**		**-13.42%**	

Medical Policy # *007005509-0000* *Renewal Date:* *11/1/2023*	Current Plan BCBSM Simply Blue PPO $250 (Current Billed Ages)		Renewal Plan - BCBSM Simply Blue PPO $250 (Renewal Billed Ages)		Platinum $0 HAP PPO		Platinum $250 HAP PPO	
Network:	Blue Cross Blue Shield of Michigan		Blue Cross Blue Shield of Michigan		HAP PPO		HAP 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:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**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:	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**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	$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****		**$0****	
Specialist Visit	$40		$40		$40		$40	
Urgent Care	$60		$60		**$65**		**$65**	
Emergency Room	$150		$150		**$200**		**$200**	
Hospital Admission	20% after Deductible		20% after Deductible		**0% after Deductible**		**0% after Deductible**	
Imaging	20% after Deductible		20% after 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		**$60**		**$60**	
Tier 4: Preferred Specialty	15% ($150 Maximum)		15% ($150 Maximum)		**20% ($200 Maximum)**		**20% ($200 Maximum)**	
Tier 5: Non-Preferred Specialty	25% ($300 Maximum)		25% ($300 Maximum)		**50% ($500 Maximum)**		**50% ($500 Maximum)**	
Prescription Formulary	**Custom Select**		**Custom Select**		**N/A**		**N/A**	
Plan Provisions:								
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Covered on Dental		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not 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%**		**13.81%**		**9.91%**	

Medical Policy # *007005509-0000* *Renewal Date:* *11/1/2023*	Current Plan BCBSM Simply Blue PPO $250 (Current Billed Ages)		Renewal Plan - BCBSM Simply Blue PPO $250 (Renewal Billed Ages)		Platinum Priority Health PPO 250 100%		Platinum Priority Health 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	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Single	$250	$500	$250	$500	$250	$500	$250	$500
Family	$500	$1,000	$500	$1,000	$500	$1,000	$500	$1,000
Coinsurance:	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	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:	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	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 after Deductible**	
Hospital Admission	20% after Deductible		20% after Deductible		**0% after Deductible**		**10% after Deductible**	
Imaging	20% after Deductible		20% after Deductible		**$150 after 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		$80		$80	
Tier 4: Preferred Specialty	15% ($150 Maximum)		15% ($150 Maximum)		**20% ($200 Maximum)**		**20% ($200 Maximum)**	
Tier 5: Non-Preferred Specialty	25% ($300 Maximum)		25% ($300 Maximum)		**20% ($300 Maximum)**		**20% ($300 Maximum)**	
Prescription Formulary	**Custom Select**		**Custom Select**		**N/A**		**N/A**	
Plan Provisions:								
Dependent Age	End of Year Age 26		End of Year Age 26		End of Year Age 26		End of Year Age 26	
Pediatric Dental	Covered on Dental		Not Included		Not Included		Not Included	
Elective Abortion	Not Included		Not Included		Not Included		Not Included	
Domestic Partner Rider	Not Included		Not Included		Not Included		Not Included	
Monthly / Annual Premium	**$2,719.11**	**$32,629.32**	**$2,871.53**	**$34,458.36**	**$2,988.83**	**$35,865.96**	**$2,929.14**	**$35,149.68**
$ Change from Current			**$152.42**	**$1,829.04**	**$269.72**	**$3,236.64**	**$210.03**	**$2,520.36**
% Change from Current			**5.61%**		**9.92%**		**7.72%**	

Dental Policy # 4544 *Renewal Date:* 11/1/2023	Current Delta Dental			Renewal Delta Dental			Guardian	
Plan Provisions:	**Delta PPO**	**Premier**	**Non-Participating**	**Delta PPO**	**Premier**	**Non-Participating**	**In-Network**	**Out-of-Network**
Network / UCR	Delta USA		Non-Par Fee	Delta USA		Non-Par Fee	DentalGuard Preferred	90th
Single Deductible	$50	$50	$50	$50	$50	$50	$50	$50
Two Person / Family Deductible	$150	$150	$150	$150	$150	$150	$150	$150
Calendar Year Max Per Person		$1,500			$1,500		$1,500	
diatric Dental EHB (Small Group Only)		Included in Rates			Included in Rates		Included in Rates	
Maximum Rollover		Not Included			Not Included		**Included**	
Preventative Advantage		Included			Included		**Included**	
Type I - Preventative Services:								
Cleanings (Oral Prophylaxis)	100%	100%	100%	100%	100%	100%	100%	100%
Frequency on Routine Cleanings	2x	2x	2x	2x	2x	2x	2x	2x
Exams	100%	100%	100%	100%	100%	100%	100%	100%
X-Rays	100%	100%	100%	100%	100%	100%	100%	100%
Fluoride Treatments	100%	100%	100%	100%	100%	100%	100%	100%
Type II - Basic Services:								
Fillings	80%	80%	80%	80%	80%	80%	80%	80%
Oral Surgery	80%	80%	80%	80%	80%	80%	80%	80%
Periodontics	80%	80%	80%	80%	80%	80%	80%	80%
Endodontics	80%	80%	80%	80%	80%	80%	80%	80%
Type III - Major Services:								
Crowns / Onlays	50%	50%	50%	50%	50%	50%	50%	50%
Bridges / Dentures	50%	50%	50%	50%	50%	50%	50%	50%
Implants	50%	50%	50%	50%	50%	50%	50%	50%
Type IV - Child Orthodontics:								
Orthodontics	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child Ortho Lifetime Max		N/A			N/A		N/A	
Additional Details:								
Participation Requirement	75% of All Eligible Employees			75% of All Eligible Employees			86% of Eligible	
Dependent Age	To End of Year Age 26			To End of Year Age 26			To End of Year Age 26	
Headcounts / Rates:								
Single 26		**$49.96**			**$51.46**		**$51.96**	
EE & Spouse 6		**$91.93**			**$94.69**		**$95.61**	
EE & Child 2		**$91.93**			**$94.69**		**$95.61**	
EE & Children 1		**$154.06**			**$158.68**		**$160.22**	
Family 3		**$154.06**			**$158.68**		**$160.22**	
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**	**$2,756.72**	**$33,080.64**
$ Change from Current				**$79.56**		**$954.72**	**$106.08**	**$1,272.96**
% Change from Current					**3.00%**			**4.00%**

Dental Policy # 4544 *Renewal Date:* 11/1/2023	Current Delta Dental			Renewal Delta Dental			Delta Dental		
Plan Provisions:									
	Delta PPO	**Premier**	**Non-Participating**	**Delta PPO**	**Premier**	**Non-Participating**	**Delta PPO**	**Premier**	**Non-Participating**
Network / UCR	Delta USA		Non-Par Fee	Delta USA		Non-Par Fee	Delta USA		Non-Par Fee
Single Deductible	$50	$50	$50	$50	$50	$50	$50	$50	$50
Two Person / Family Deductible	$150	$150	$150	$150	$150	$150	$150	$150	$150
Calendar Year Max Per Person		$1,500			$1,500			**$2,000**	
diatric Dental EHB (Small Group Only)		Included in Rates			Included in Rates			Included in Rates	
Maximum Rollover		Not Included			Not Included			Not Included	
Preventative Advantage		Included			Included			Included	
Type I - Preventative Services:									
Cleanings (Oral Prophylaxis)	100%	100%	100%	100%	100%	100%	100%	100%	100%
Frequency on Routine Cleanings	2x	2x	2x	2x	2x	2x	2x	2x	2x
Exams	100%	100%	100%	100%	100%	100%	100%	100%	100%
X-Rays	100%	100%	100%	100%	100%	100%	100%	100%	100%
Fluoride Treatments	100%	100%	100%	100%	100%	100%	100%	100%	100%
Type II - Basic Services:									
Fillings	80%	80%	80%	80%	80%	80%	80%	80%	80%
Oral Surgery	80%	80%	80%	80%	80%	80%	80%	80%	80%
Periodontics	80%	80%	80%	80%	80%	80%	80%	80%	80%
Endodontics	80%	80%	80%	80%	80%	80%	80%	80%	80%
Type III - Major Services:									
Crowns / Onlays	50%	50%	50%	50%	50%	50%	50%	50%	50%
Bridges / Dentures	50%	50%	50%	50%	50%	50%	50%	50%	50%
Implants	50%	50%	50%	50%	50%	50%	50%	50%	50%
Type IV - Child Orthodontics:									
Orthodontics	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child Ortho Lifetime Max		N/A			N/A			N/A	
Additional Details:									
Participation Requirement	75% of All Eligible Employees			75% of All Eligible Employees			75% of All Eligible Employees		
Dependent Age	To End of Year Age 26			To End of Year Age 26			To End of Year Age 26		
Headcounts / Rates:									
Single **26**		**$49.96**			**$51.46**			**$52.79**	
EE & Spouse **6**		**$91.93**			**$94.69**			**$97.15**	
EE & Child **2**		**$91.93**			**$94.69**			**$97.15**	
EE & Children **1**		**$154.06**			**$158.68**			**$162.81**	
Family **3**		**$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 from Current				**$79.56**		**$954.72**	**$150.34**		**$1,804.08**
% Change from Current					**3.00%**			**5.67%**	

		Current Plan BCBSM		Renewal Plan BCBSM		UNUM		Delta Vision	
Vision Policy #	007005509-0000 & 00125981-0001-0001								
Renewal Date:	45231								
Plan Co-Payments:									
		In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Examinations		$5	Up to $34	$5	Up to $34	**$10**	**Up to $40**	**$10**	**Up to $45**
Materials		$10		$10		$10		**$25**	
Frequency (# of Months):		***Once Every:***		***Once Every:***		***Once 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:		***Up to:***		***Up to:***		***Up to:***		***Up to:***	
Single 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**
Lenticular 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	$130	**$91**	$130	**$70**
Medically Necessary Contacts		Paid-in-Full[4]	$210	Paid-in-Full[4]	$210	Paid-in-Full[4]	$210	Paid-in-Full[4]	$210
Elective Contacts		$130	$100	$130	$100	$130	**$130**	$130	**$105**
Plan Provisions:									
Network		**VSP Choice**		**VSP Choice**		**EyeMed Insight**		**VSP Choice**	
Contact Lenses in Lieu of Frames		No		No		**Yes**		**Yes**	
Frame Discount		No		No		**Yes**		**Yes**	
Lens Discount		No		No		**Yes**		**Yes**	
Dependent Age		To End of Year Age 26		To End of Year Age 26		To End of Year Age 26		To End of Year Age 26	
Participation Requirement		Sold with BCBSM Medical		Sold with BCBSM Medical		85% of Total Eligible		Min. 2 Enrolled - Sold w/ Delta Dental	
Headcounts / Rates:									
Single	**27**	**Age Banded**		**Age Banded**		**$5.17**		**$5.60**	
EE & Spouse	**2**	**Age Banded**		**Age Banded**		**$10.33**		**$11.20**	
EE & Child	**2**	**Age Banded**		**Age Banded**		**$11.31**		**$11.99**	
EE & Children	**1**	**Age Banded**		**Age Banded**		**$11.31**		**$11.99**	
Family	**3**	**Age Banded**		**Age Banded**		**$17.77**		**$19.16**	
Total Enrolled	**35**								
Rate Guarantee Duration				12 Months		**48 Months**		12 Months	
Monthly / 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				**$5.02**	**$60.24**	**$85.56**	**$1,026.72**	**$105.12**	**$1,261.44**
% Change from Current				**3.10%**		**52.84%**		**64.92%**	

		Current Plan BCBSM		Renewal Plan BCBSM		UNUM		Delta Vision	
Vision Policy #	007005509-0000 & 00125981-0001-0001								
Renewal Date:	45231								
Plan Co-Payments:									
		In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Examinations		$5	Up to $34	$5	Up to $34	**$10**	**Up to $40**	**$10**	**Up to $45**
Materials		$10		$10		$10		**$25**	
Frequency (# of Months):		***Once Every:***		***Once Every:***		***Once 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:		***Up to:***		***Up to:***		***Up to:***		***Up to:***	
Single 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**
Lenticular 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**
Medically Necessary Contacts		Paid-in-Full[4]	$210	Paid-in-Full[4]	$210	Paid-in-Full[4]	$210	Paid-in-Full[4]	$210
Elective Contacts		$130	$100	$130	$100	**$150**	**$150**	**$150**	**$105**
Plan Provisions:									
Network		**VSP Choice**		**VSP Choice**		**EyeMed Insight**		**VSP Choice**	
Contact Lenses in Lieu of Frames		No		No		**Yes**		**Yes**	
Frame Discount		No		No		**Yes**		**Yes**	
Lens Discount		No		No		**Yes**		**Yes**	
Dependent Age		To End of Year Age 26		To End of Year Age 26		To End of Year Age 26		To End of Year Age 26	
Participation Requirement		Sold with BCBSM Medical		Sold with BCBSM Medical		85% of Total Eligible		Min. 2 Enrolled - Sold w/ Delta Dental	
Headcounts / Rates:									
Single	**27**	**Age Banded**		**Age Banded**		**$5.60**		**$5.88**	
EE & Spouse	**2**	**Age Banded**		**Age Banded**		**$11.21**		**$11.76**	
EE & Child	**2**	**Age Banded**		**Age Banded**		**$12.21**		**$12.59**	
EE & Children	**1**	**Age Banded**		**Age Banded**		**$12.21**		**$12.59**	
Family	**3**	**Age Banded**		**Age Banded**		**$19.20**		**$20.12**	
Total Enrolled	**35**								
Rate Guarantee Duration				12 Months		**48 Months**		12 Months	
Monthly / Annual Premium		**$161.93**	**$1,943.16**	**$166.95**	**$2,003.40**	**$267.85**	**$3,214.20**	**$280.41**	**$3,364.92**
$ Change from Current				**$5.02**	**$60.24**	**$105.92**	**$1,271.04**	**$118.48**	**$1,421.76**
% Change from Current				**3.10%**		**65.41%**		**73.17%**	