Summary of Benefits		Blue Cross Blue Shield		Priority Health		Priority Health		Priority Health	Blue Cross Blue Shield Option	
		MESSA ABC Plan 1		**PriorityHSA PPO 1350 2-tier Rx**		**PriorityHSA POS 1350 2-tier Rx**		**Priority HAS HMO 1350 2-tier Rx**	**BCBS Simply Blue HAS PPO 1350 Gold**	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	In-Network	Out-of-Network
Medical		*Full Family deductible must be met before benefits are paid for any person on the contract*		*Full Family deductible must be met before benefits are paid for any person on the contract*		*Full Family duductibel must be met before benefits are paid for any person on the contract*		*Full Family deductible must be met before benefits are paid for any person on the contract*	*Full Family deductible must be met before benefits are paid for any person on the contract*	
Annual Deductible		$1,300 per individual $2,600 per family	$2,600 per individual $5,200 per family	**$1,350 per individual $2,700 per family**	**$2,700 per individual $5,400 per family**	**$1,350 per individual $2,700 per family**	**$2,700 per individual $5,400 per family**	**$1,350 per individual $2,700 per family**	**$1,350 per individual $2,700 per family**	**$2,7000 per individual $5,400 per family**
Coinsurance (after Deductible is met)		0%	20%	**10%**	**30%**	**10%**	**30%**	**10%**	0%	20%
Copays										
Office Visit Non Specialist		0% after deductible	20% after deductible	**10% after deductible**	**30% after deductible**	**10% after deductible**	**30% after deductible**	**10% after deductible**	0% after deductible	20% after deductible
Office Visit Specialist		0% after deductible	20% after deductible	**10% after deductible**	**30% after deductible**	**10% after deductible**	**30% after deductible**	**10% after deductible**	0% after deductible	20% after deductible
Emergency Room		0% after deductible	0% after deductible	**10% after deductible**	**10% after deductible**	**10% after deductible**	**10% after deductible**	**10% after deductible**	0% after deductible	0% after deductible
Urgent Care		0% after deductible	20% after deductible	**10% after deductible**	**30% after deductible**	**10% after deductible**	**30% after deductible**	**10% after deductible**	0% after deductible	20% after deductible
Hospital Services		Inpatient and Outpatient - 0% after deductible	Inpatient and Outpatient - 20% after deductible	**Inpatient and Outpatient - 10% after deductible**	**Inpatient and Outpatient - 30% after deductible**	**Inpatient and Outpatient - 10% after deductible**	**Inpatient and Outpatient - 30% after deductible**	**Inpatient and Outpatient - 10% after deductible**	Inpatient and Outpatient - 0% after deductible	Inpatient and Outpatient - 20% after deductible
Prescription Copays		Medical deductible must be met before copays apply		Medical deductible must be met before copays apply		Medical deductible must be met before copays apply		Medical deductible must be met before copays apply	Medical deductible must be met before copays apply	
Generic/Tier 1		$10 copay	*Copay + 20% Approved Amount	$10 copay	Copay + 20% Approved Amount	$10 copay	Copay + 20% Approved Amount	$10 copay	$10 copay	Copay + 20% Approved Amount
Preferred Brand/Tier 2		$20 copay		$40 copay		$40 copay		$40 copay	$40 copay	
Non-Preferred Brand/Tier 3		$40 copay		$80 copay		$80 copay		$80 copay	$80 copay	
Specialty/Tier 4		$40 copay		15% (max of $150)		15% (max of $150)		15% (max of $150)	15% (max of $150)	
Specialty/Tier 5		$40 copay		25% (max of $300)		25% (max of $300)		25% (max of $300)	25% (max of $300)	
Pediatric Services										
Pediatric Dental		included for additional rate		included for additional rate		included for additional rate		included for additional rate	included for additional rate	
Pediatric Vision		Included		Included		Included		Included	Included	
Annual Combined Out of Pocket Max (includes Deductible, Copays & Co-Insurance)		$2,300 per individual $4,600 per family	$4,600 per individual $9,200 per family	**$2,400 per individual $4,800 per family**	**$4,800 per individual $9,600 per family**	**$2,400 per individual $4,800 per family**	**$4,800 per individual $9,600 per family**	**$2,400 per individual $4,800 per family**	**$2,350 per individual $4,700 per family**	**$4,700 per individual $9,400 per family**
		Current	**Renewal**	**Priority Option A**		**Priority Option B**		**Priority Option C**	**BCBSM Option 1**	
		Effective 7/1/2015	**Effective 7/1/2016**	**Effective 7/1/2016**		**Effective 7/1/2016**		**Effective 7/1/2016**	**Effective 7/1/2016**	
Coverage Type	**Census (based on BCBSM April 2016 invoice)**									
		Medical + Rx. Rates Effective 7/1/2015	**Medical + Rx. Rates Effective 7/1/2016**	**Medical + Rx. Rate Equivalent Effective 7/1/2016**		**Medical + Rx. Rate Equivalent Effective 7/1/2016**		**Medical + Rx. Rate Equivalent Effective 7/1/2016**	**Medical + Rx. Rate Equivalent Effective 7/1/2016**	
Employee Only	0	$580.50	$663.15	$604.70		$585.40		$559.34	$577.54	
Emplyee & One Dependent	0	$1,304.24	$1,490.21	$1,358.86		$1,315.49		$1,256.94	$1,297.82	
Family	7	$1,622.69	$1,854.11	$1,690.69		$1,636.72		$1,563.87	$1,614.74	
Total Monthly Premium	**7**	**$11,358.83**	**$12,978.77**	**$11,834.80**		**$11,457.07**		**$10,947.12**	**$11,303.21**	
% Change			**14.26%**	**4.19%**		**0.86%**		**-3.62%**	**-0.49%**	
Total Annual Premium	**7**	**$136,305.96**	**$155,745.24**	**$142,017.60**		**$137,484.88**		**$131,365.46**	**$135,638.52**	

Summary of Benefits		Blue Cross Blue Shield		**Priority Health**		**Priority Health**		**Priority Health**	**Priority Health**		Blue Cross Blue Shield Option	
		MESSA Choices $500/1,000		**Priority PPO 500 2-tier Rx**		**Priority POS 500 2-tier Rx**		**Priority HMO 500 2-tier Rx**	**Priority PPO 250 100%**		**Community Blue PPO Platinum $500**	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Medical												
Annual Deductible		$500 per individual $1,000 per family	$1,000 per individual $2,000 per family	$500 per individual $1,000 per family	$1,000 per individual $2,000 per family	$500 per individual $1,000 per family	$1,000 per individual $2,000 per family	$500 per individual $1,000 per family	$250 per individual $500 per family	$500 per individual $1,000 per family	$500 per individual $1,000 per family	$1,000 per individual $2,000 per family
Coinsurance (after Deductible is met)		**0%**	**20%**	**20%**	**40%**	**20%**	**40%**	**20%**	**0%**	**20%**	**10%**	**30%**
Copays												
Office Visit Non Specialist		$20	20% after deductible	$20	40% after deductible	$20	40% after deductible	$20	**$10**	20% after deductible	$20	**30% after deductible**
Office Visit Specialist		$20	20% after deductible	**$35**	40% after deductible	**$35**	40% after deductible	**$35**	**$25**	20% after deductible	$20	**30% after deductible**
Emergency Room		$50	$50	**$150**	**$150**	**$150**	**$150**	**$150**	**$150**	**$150**	**$150**	**$150**
Urgent Care		$25	20% after deductible	**$75**	40% after deductible	**$75**	40% after deductible	**$75**	**$75**	20% after deductible	**$60**	**30% after deductible**
Hospital Services		Inpatient and Outpatient - 0% after deductible	Inpatient and Outpatient - 20% after deductible	Inpatient and Outpatient - 20% after deductible	Inpatient and Outpatient - 40% after deductible	Inpatient and Outpatient - 20% after deductible	Inpatient and Outpatient - 40% after deductible	Inpatient and Outpatient - 20% after deductible	Inpatient and Outpatient - 0% after deductible	Inpatient and Outpatient - 20% after deductible	Inpatient and Outpatient - 20% after deductible	**Inpatient and Outpatient - 30% after deductible**
Prescription												
Copays												
Generic/Tier 1		$10 copay	*Copay + 20% Approved Amount	$10 copay	Copay + 20% Approved Amount	$10 copay	Copay + 20% Approved Amount	$10 copay	$10 copay	Copay + 20% Approved Amount	**$5 copay**	Copay + 25% Approved Amount
Preferred Brand/Tier 2		$20 copay		**$40 copay**		**$40 copay**		**$40 copay**	**$40 copay**		**$40 copay**	
Non-Preferred Brand/Tier 3		$40 copay		$40 copay		$40 copay		$40 copay	$40 copay		**$80 copay**	
Specialty/Tier 4		$40 copay		$40 copay		$40 copay		$40 copay	$40 copay		**$80 copay**	
Specialty/Tier 5		$40 copay		$40 copay		$40 copay		$40 copay	$40 copay		**$80 copay**	
Pediatric Services												
Pediatric Dental		included for additional rate		included for additional rate		included for additional rate		included for additional rate	included for additional rate		included for additional rate	
Pediatric Vision		Included		Included		Included		Included	Included		Included	
Annual Combined Out of Pocket Max (includes Deductible, Copays & Co-Insurance)		$2,300 per individual $4,600 per family	$4,600 per individual $9,200 per family	$5,000 per individual $10,000 per family	$10,000 per individual $20,000 per family	$5,000 per individual $10,000 per family	$10,000 per individual $20,000 per family	$5,000 per individual $10,000 per family	$1,400 per individual $2,800 per family	$2,800 per individual $5,600 per family	$6,600 per individual $13,200 per family	$13,000 per individual $26,400 per family
		Current	**Renewal**	**Priority Option A**		**Priority Option B**		**Priority Option C**	**Priority Option G**		**BCBSM Option 1**	
		Effective 7/1/2015	**Effective 7/1/2016**	**Effective 7/1/2016**		**Effective 7/1/2016**		**Effective 7/1/2016**	**Effective 7/1/2016**		**Effective 7/1/2016**	
Coverage Type	**Census (based on BCBSM April 2016 invoice)**											
Employee Only	1	$641.62	$736.67	$588.50		$575.48		$545.39	$712.70		$629.90	
Emplyee & One Dependent	2	$1,441.77	$1,655.62	$1,322.47		$1,293.20		$1,225.59	$1,601.56		$1,415.49	
Family	11	$1,793.83	$2,059.96	$1,645.40		$1,609.00		$1,524.87	$1,992.65		$1,761.14	
Total Monthly Premium	**14**	**$23,257.29**	**$26,707.47**	**$21,332.89**		**$20,860.85**		**$19,770.11**	**$25,834.93**		**$22,833.41**	
% Change			**14.83%**	**-8.27%**		**-10.30%**		**-14.99%**	**11.08%**		**-1.82%**	
Total Annual Premium	**14**	**$279,087.48**	**$320,489.64**	**$255,994.68**		**$250,330.24**		**$237,241.34**	**$310,019.12**		**$274,000.92**	