ANTHONY AND ASSOCIATES

Livingston Educational Service Agency

Quoting Summary - Transportation

Rates Effective 7/1/2017

Blue Cross Blue Shield of Michigan	Quote Received
Blue Care Network	Quote Received
Priority Health	Quote Received
Health Alliance Plan (HAP)	Quote Received
Total Health Care	Declined to Quote
National Insurance Services	Quote Received
Ameritas	Quote Received

ANTHONY AND ASSOCIATES

Livingston Educational Service Agency
Medical/ Rx Options - Transportation
Effective: July 1, 2017

		Option 1	Option 2	Option 3	Option 4	Option 5	Option 6
Insurance Carrier		**Blue Cross Blue Shield**	**Blue Cross Blue Shield**	**Blue Cross Blue Shield**	**Blue Cross Blue Shield**	**Blue Care Network**	**Blue Care Network**
Plan Name		Simply Blue HSA $1300/0%	Simply Blue HSA $1300/20%	Simply Blue HSA $2000/20%	Simply Blue HSA $500	BCN HMO $500	BCN HSA $1350/0%
Plan Type		PPO	PPO	PPO	PPO	HMO	HMO
HSA Compatible		Yes	Yes	Yes	No	No	Yes
Estimated Single Rate	**188**	$662.13	$606.53	$539.24	$780.94	$603.07	$532.81
Estimated Two Person Rate	**8**	$1,589.11	$1,455.67	$1,294.17	$1,874.26	$1,447.37	$1,278.75
Estimated Family Rate	**8**	$1,986.39	$1,819.59	$1,617.71	$2,342.82	$1,809.21	$1,598.44
Estimated Monthly Premium		**$153,084.44**	**$140,229.72**	**$124,672.16**	**$180,553.36**	**$139,429.80**	**$123,185.80**
Estimated Annual Premium		**$1,837,013.28**	**$1,682,756.64**	**$1,496,065.92**	**$2,166,640.32**	**$1,673,157.60**	**$1,478,229.60**
Estimated Monthly Taxes		**Included in Rate**	**Included in Rate**	**Included in Rate**	**Included in Rate**	**Included in Rate**	**Included in Rate**
In-Network Services							
Deductible		$1,300/$2,600	$1,300/$2,600	$2,000/$4,000	$500/$1,000	$500/$1,000	$1,350/$2,700
Coinsurance		0% after deductible for most services	20% after deductible for most services	20% after deductible for most services	20% after deductible for most services	0% after deductible for most services	0% after deductible for most services
Out -of-Pocket Maximum		$2,250/$4,500	$2,250/$4,500	$3,000/$6,000	$2,000/4,000	$1,000/$2,000	2,350/4,670
Office Visit		0% after deductible	20% after deductible	20% after deductible	$ 20 after deductible	$20	0% after deductible
Specialist Visit		0% after deductible	20% after deductible	20% after deductible	$40 after deductible	$30	0% after deductible
Urgent Care Visit		0% after deductible	20% after deductible	20% after deductible	$60 after deductible	$35	0% after deductible
Emergency Room Visit		0% after deductible	20% after deductible	20% after deductible	$150 after deductible	$150	0% after deductible
Prescription Drugs							
Tier 1 - Generic		$15 after deductible	$15 after deductible	$15 after deductible	$15	$10 or $30	$10 or $30 after deductible
Tier 2 - Preferred Brand		$ 30 after deductible	$ 30 after deductible	$ 30 after deductible	$30	$60	$ 60 after deductible
Tier 3 - Nonpreferred Brand		$60 after deductible	$60 after deductible	$60 after deductible	$60	$80	$80 after deductible
Tier 4 - Preferred Specialty		$60 after deductible	$60 after deductible	$60 after deductible	$60	20%	20% after deductible max $200
Tier 5 - Non Preferred Specialty		$60 after deductible	$60 after deductible	$60 after deductible	$60	20%	20% after deductible max $300
Out -of- Network Services							
Deductible		$2,600/$5,200	$2,600/$5,200	$4,000/$8,000	$1,000/$2,000	Not Covered	Not Covered
Coinsurance		20% after deductible for most services	40% after deductible for most services	40% after deductible for most services	40% after deductible for most services	Not Covered	Not Covered
Out -of-Pocket Maximum		$4,500/$9,000	$4,500/$9,000	$6,000/$12,000	$4,000/$8,000	Not Covered	Not Covered
Office Visit		20% after deductible	40% after deductible	40% after deductible	40% after deductible	Not Covered	Not Covered
Specialist Visit		20% after deductible	40% after deductible	40% after deductible	40% after deductible	Not Covered	Not Covered
Urgent Care Visit		20% after deductible	40% after deductible	40% after deductible	40% after deductible	Not Covered	Not Covered
Emergency Room Visit		20% after deductible	40% after deductible	40% after deductible	40% after deductible	Not Covered	Not Covered
Prescription Drugs							
Tier 1 - Generic						Not Covered	Not Covered
Tier 2 - Preferred Brand						Not Covered	Not Covered
Tier 3 - Nonpreferred Brand		Applicable copay after deductible plus an additional 20% BCBSM approved amount of the drug	Applicable copay after deductible plus an additional 20% BCBSM approved amount of the drug	Applicable copay after deductible plus an additional 20% BCBSM approved amount of the drug	Applicable copay after deductible plus an additional 20% BCBSM approved amount of the drug	Not Covered	Not Covered
Tier 4 - Preferred Specialty						Not Covered	Not Covered
Tier 5 - Non Preferred Specialty						Not Covered	Not Covered

Please Note: Rates are estimated and are provided for informational purposes only. Rates may vary due to rounding. Total Costs are assuming 100% participation. Final determination will be made at time of enrollment. Quoted rates are based on all elgible employee enrolling. Enrollment status is estimated. Applicable taxes may apply. Not intended to be a complete comaparsion of plans, please see the Summary of Benefit Coverage for benefit coverage details.

ANTHONY AND ASSOCIATES

Livingston Educational Service Agency
Medical/ Rx Options - Transportation
Effective: July 1, 2017

		Option 7	Option 8	Option 9	Option 10	Option 11	Option 12
Insurance Carrier		**Priority Health**	**Priority Health**	**Priority Health**	**HAP**	**HAP**	**HAP**
Plan Name		PPO 2000 HSA 20%	POS 1000 10%	HMO 1000 10%	Option 3 - NEW QHDHP	Option 5 - NEW QHDHP	Option 5 - NEW QHDHP
Plan Type		PPO	POS	HMO	PPO	PPO	HMO
HSA Compatible		Yes	No	No	Yes	Yes	Yes
Single Rate	**188**	$654.67	$913.06	$860.16	$976.91	$921.62	$609.54
Two Person Rate	**8**	$1,440.28	$2,008.73	$1,892.35	$2,344.58	$2,211.86	$1,401.43
Family Rate	**8**	$1,898.54	$2,647.87	$2,494.46	$2,930.73	$2,764.83	$1,584.80
Estimated Monthly Premium		**$149,788.52**	**$208,908.08**	**$196,804.56**	**$225,861.56**	**$213,078.08**	**$5,426,305.34**
Estimated Annual Premium		**$1,797,462.24**	**$2,506,896.96**	**$2,361,654.72**	**$2,710,338.72**	**$2,556,936.96**	**$65,115,664.13**
Estimated Monthly Taxes		**Included in Premium**	**Included in Rate**	**Included in Rate**	**Included in Rate**	**Included in Rate**	**Included in Rate**
In-Network Services							
Deductible		$2,000/$4,000	$1,000/$2,000	$1,000/$2,000	$1,300/$2,600	$2,000/$4,000	$2,500/$5,000
Coinsurance		20% after deductible for most services	10% after deductible for most services	10% after deductible for most services	20% after deductible for most services	20% after deductible for most services	20% after deductible for most services
Out -of-Pocket Maximum		$4,000/$8,000	$7,150/14,300	$7,150/14,300	$2,300/$4,600	$3,000/$6,000	$5,000/$10,000
Office Visit		20% after deductible	$20	$20	20% after deductible	20% after deductible	20% after deductible
Specialist Visit		20% after deductible	$35	$35	20% after deductible	20% after deductible	20% after deductible
Urgent Care Visit		20% after deductible	$75	$75	20% after deductible	20% after deductible	20% after deductible
Emergency Room Visit		20% after deductible	$150	$150	20% after deductible	20% after deductible	20% after deductible
Prescription Drugs							
Tier 1 - Generic		$10 after deductible	$10	$10	$10 after deductible	$10 after deductible	$10 after deductible
Tier 2 - Preferred Brand		$ 40 after deductible	$40	$40	$ 20 after deductible	$ 20 after deductible	$ 20 after deductible
Tier 3 - Nonpreferred Brand		$80 after deductible	$80	$80	$40 after deductible	$40 after deductible	$40 after deductible
Tier 4 - Preferred Specialty		$40 after deductible	$40	$40	$40 after deductible	$40 after deductible	$40 after deductible
Tier 5 - Non Preferred Specialty		$80 after deductible	$80	$80	$40 after deductible	$40 after deductible	$40 after deductible
Out -of- Network Services			Alternate Benefit				
Deductible		$4,000/$8,000	$2,000/$4,000	Not Covered	$2,300/$4,600	$4,000/$8,000	Not Covered
Coinsurance		40% after deductible for most services	30% after deductible for most services	Not Covered	40% after deductible for most services	40% after deductible for most services	Not Covered
Out -of-Pocket Maximum		$8,000/$16,000	$14,300/$28,600	Not Covered	$4,600/$9,200	$6,000/$12,000	Not Covered
Office Visit		40% after deductible	30% after deductible	Not Covered	40% after deductible	40% after deductible	Not Covered
Specialist Visit		40% after deductible	30% after deductible	Not Covered	40% after deductible	40% after deductible	Not Covered
Urgent Care Visit		40% after deductible	30% after deductible	Not Covered	40% after deductible	40% after deductible	Not Covered
Emergency Room Visit		40% after deductible	$150	Not Covered	40% after deductible	40% after deductible	Not Covered
Prescription Drugs							
Tier 1 - Generic							
Tier 2 - Preferred Brand							
Tier 3 - Nonpreferred Brand							
Tier 4 - Preferred Specialty		Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Tier 5 - Non Preferred Specialty							

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