



Medical Rate Summary
St. Joseph Public Schools
All Employee Options
 Assumed Effective Date: 7/1/2020

Current Plan(s) and Segment:		1P	2P	FF		Total Annual Cost
All Employees Enrolled in MESSA PAK D Essentials \$375	Census	1	1		2	
MESSA Essentials \$375-20%; Essentials Rx	Rate	\$453.90	\$1,019.41	\$1,268.21		\$17,680
All Employees Enrolled in MESSA PAK A Choices \$500	Census	20	13	44	77	
MESSA Choices \$500-0%; Saver Rx	Rate	\$675.36	\$1,517.69	\$1,888.30		\$1,395,868
All Employees Enrolled in MESSA PAK C ABC Plan 1 \$1400	Census	10	13	57	80	
MESSA ABC Plan 1 \$1400-0%; ABC Rx	Rate	\$603.12	\$1,355.17	\$1,686.05		\$1,437,039
All Employees Enrolled in MESSA Non-PAK ABC Plan 1 \$1400	Census	5			5	
MESSA ABC Plan 1 \$1400-0%; ABC Rx	Rate	\$615.40	\$1,382.79	\$1,720.43		\$36,924
TOTALS:		36	27	101	164	\$2,887,511

Product Name	1P Rate	2P Rate	FF Rate	Total Annual Cost	Estimated Annual Savings
BCBSM Simply Blue Plans					
BCBSM SB PPO \$250-20%; \$1500 ECM; \$10/\$40/\$80 Rx	\$651	\$1,563	\$1,954	\$3,156,123	-\$268,612
BCBSM SB PPO \$500-20%; \$1500 ECM; \$10/\$40/\$80 Rx	\$632	\$1,517	\$1,896	\$3,063,106	-\$175,595
BCBSM Simply Blue HSA Plans					
BCBSM SB PPO HSA \$1400-0%; \$10/\$40/\$80 Rx	\$574	\$1,378	\$1,722	\$2,781,269	\$106,242
BCBSM SB PPO HSA \$1400-20%; \$10/\$40/\$80 Rx	\$539	\$1,293	\$1,616	\$2,610,610	\$276,901
McLaren	Solicited and declined to quote				
Priority Health	Solicited and declined to quote				
MESSA	Solicited and did not provide options				

*MESSA rates include taxes and fees.

*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 commission. SET SEG has added 3% to the quoted rates to account for commission.



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**St. Joseph Public Schools
All Employee Options
Assumed Effective Date: 7/1/2020**

Plan	CURRENT PLAN		CURRENT PLAN		CURRENT PLAN		CURRENT PLAN		Option 1	Option 2
	All Employees Enrolled in MESSA PAK D Essentials \$375		All Employees Enrolled in MESSA PAK A Choices \$500		All Employees Enrolled in MESSA PAK C ABC Plan 1 \$1400		All Employees Enrolled in MESSA Non-PAK ABC Plan 1 \$1400		BCBSM SB PPO HSA \$1400-0%; \$10/\$40/\$80 Rx	BCBSM SB PPO HSA \$1400-20%; \$10/\$40/\$80 Rx
	MESSA Essentials \$375-20%; Essentials Rx		MESSA Choices \$500-0%; Saver Rx		MESSA ABC Plan 1 \$1400-0%; ABC Rx		MESSA ABC Plan 1 \$1400-0%; ABC Rx			
Rate Period	1/1/2020-12/31/2020		1/1/2020-12/31/2020		1/1/2020-12/31/2020		1/1/2020-12/31/2020		7/1/2020-6/30/2021	7/1/2020-6/30/2021
Purchased Plan Features	In Network		In Network		In Network		In Network		In Network	In Network
Deductible										
Annual Deductible - 1P	\$375		\$500		\$1,400		\$1,400		\$1,400	\$1,400
Annual Deductible - 2P/FF	\$750		\$1,000		\$2,800		\$2,800		\$2,800	\$2,800
Additional Cost After Deductible										
Employee Coinsurance after Deductible	20%		0%		0%		0%		0%	20%
Coinsurance Max - 1P	N/A		N/A		N/A		N/A		N/A	N/A
Coinsurance Max - 2P/FF	N/A		N/A		N/A		N/A		N/A	N/A
Out of Pocket Maximum										
Max ded, coinsurance, copays - 1P	\$8,150		Med Max:\$1,500 Rx Max: \$1,000		\$2,400		\$2,400		\$2,250	\$2,250
Max ded, coinsurance, copays - 2P/FF	\$16,300		Med Max: \$3,000 Rx Max: \$2,000		\$4,800		\$4,800		\$4,500	\$4,500
Copayments										
Office Visit/Specialist	\$25/\$50 after Deductible		\$20/\$20 after Ded.		0% after Ded.		0% after Ded.		0% after Ded.	20% after Ded.
Urgent Care/ER	\$50/\$200 after Deductible		\$25/\$50 after Ded.		0% after Ded.		0% after Ded.		0% after Ded.	20% after Ded.
Chiropractic Limit/Copay	12/Subject to Office Copay, Deductible and Coinsurance		38/Subject to Deductible and Coinsurance		38/0% after Ded.		38/0% after Ded.		12/0% after Ded.	12/20% after Ded.
Rx Copay	Essentials Rx		Saver Rx		ABC Rx		ABC Rx		\$10/\$40/\$80 after Ded.	\$10/\$40/\$80 after Ded.
Total Monthly Costs	Census	Rates	Census	Rates	Census	Rates	Census	Rates	Census	Rates
One Person (1P)	1	\$453.90	20	\$675.36	10	\$603.12	5	\$615.40	36	\$573.98
Two Person (2P)	1	\$1,019.41	13	\$1,517.69	13	\$1,355.17	0	\$1,382.79	27	\$1,377.55
Family (FF)	0	\$1,268.21	44	\$1,888.30	57	\$1,686.05	0	\$1,720.43	101	\$1,721.93
Total Annual Premium	2	\$17,680	77	\$1,395,868	80	\$1,437,039	5	\$36,924	164	\$2,781,269
Combined Current Lives	164		< TOTALS		< TOTALS		< TOTALS			
Combined Annual Premium	\$2,887,511		< TOTALS		< TOTALS		< TOTALS			
One Person Cost Share										
One Person Rate	\$453.90		\$675.36		\$603.12		\$615.40		\$573.98	\$538.76
One Person PA 152 Cap	\$568.24		\$568.24		\$568.24		\$568.24		\$568.24	\$568.24
One Person Monthly Cost	-\$114.34		\$107.12		\$34.88		\$47.16		\$5.74	-\$29.48
Two Person Cost Share										
Two Person Rate	\$1,019.41		\$1,517.69		\$1,355.17		\$1,382.79		\$1,377.55	\$1,293.02
Two Person PA 152 Cap	\$1,188.36		\$1,188.36		\$1,188.36		\$1,188.36		\$1,188.36	\$1,188.36
Two Person Monthly Cost	-\$168.95		\$329.33		\$166.81		\$194.43		\$189.19	\$104.66
Family Cost Share										
Family Rate	\$1,268.21		\$1,888.30		\$1,686.05		\$1,720.43		\$1,721.93	\$1,616.28
Family PA 152 Cap	\$1,549.75		\$1,549.75		\$1,549.75		\$1,549.75		\$1,549.75	\$1,549.75
Family Monthly Cost	-\$281.54		\$338.55		\$136.30		\$170.68		\$172.19	\$66.53

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Dental Rate Summary
St. Joseph Public Schools
Administration & Secretary
Assumed Effective Date: 7/1/2020

Current Plan(s) and Segment:		1P	2P	FF	Monthly Composite	Total Annual Cost	Rate Period
PAK A, C & D Administration & Secretary	Census	3	4	15	\$72.81	\$19,221	1/1/2020-12/31/2020
MESSA Dental 75/75/50/75; \$1000/\$1000	Rate	\$23.81	\$45.04	\$90.01			
PAK B Administration & Secretary	Census		1	11	\$86.48	\$12,454	1/1/2020-12/31/2020
MESSA Dental 75/75/50/75; \$1000/\$1000	Rate	\$25.52	\$47.69	\$90.01			
TOTALS:		3	5	26		\$31,674	

Product Name	Rate Period	1P Rate	2P Rate	FF Rate	Monthly Composite	Total Cost	Estimated Annual Savings
Guardian Dental 75/75/50/60; \$1000/\$1000	7/1/2020-6/30/2021	\$31.75	\$63.40	\$117.07	\$101.65	\$41,473	-\$9,798
MetLife Dental 75/75/50/75; \$1000/\$1000	7/1/2020-6/30/2021	\$27.60	\$53.19	\$91.94	\$80.56	\$32,870	-\$1,196
SunLife		Solicited and declined to quote					
MESSA		Solicited and did not provide options					

*All current and proposed rates include taxes and fees.

*Guardian Dental and Vision rates are sold as package and cannot be offered as standalone product. Rates are only valid for All Employees sale.

*Guardian Dental Annual Limits include Maximum Rollover benefit.



Dental Rate Summary
St. Joseph Public Schools
Maintenance
Assumed Effective Date: 7/1/2020

Current Plan(s) and Segment:		1P	2P	FF	Monthly Composite	Total Annual Cost	Rate Period
PAK A, C & D Maintenance	Census	3	4	4	\$62.58	\$8,261	1/1/2020-12/31/2020
MESSA Dental 75/75/50; \$1000 (No Ortho)	Rate	\$29.49	\$54.02	\$95.96			
PAK B Maintenance	Census						1/1/2020-12/31/2020
MESSA Dental 75/75/50; \$1000 (No Ortho)	Rate	\$31.59	\$58.32	\$96.04			
TOTALS:		3	4	4		\$8,261	

Product Name	Rate Period	1P Rate	2P Rate	FF Rate	Monthly Composite	Total Cost	Estimated Annual Savings
Guardian Dental 75/75/50; \$1000 (No Ortho)	7/1/2020-6/30/2021	\$33.28	\$65.18	\$113.86	\$74.18	\$9,792	-\$1,531
MetLife Dental 75/75/50; \$1000 (No Ortho)	7/1/2020-6/30/2021	\$28.17	\$53.69	\$87.87	\$59.16	\$7,809	\$452
SunLife		Solicited and declined to quote					
MESSA		Solicited and did not provide options					

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*Guardian Dental Annual Limits include Maximum Rollover benefit.



Dental Rate Summary
St. Joseph Public Schools
Teachers
Assumed Effective Date: 7/1/2020

Current Plan(s) and Segment:		1P	2P	FF	Monthly Composite	Total Annual Cost	Rate Period
PAK A, C & D Teachers	Census	25	20	81	\$74.32	\$112,370	1/1/2020-12/31/2020
MESSA Dental 75/75/50/75; \$1500/\$1000	Rate	\$26.71	\$50.15	\$94.98			
PAK B Teachers	Census	3	2	22	\$84.33	\$27,323	1/1/2020-12/31/2020
MESSA Dental 75/75/50/75; \$1500/\$1000	Rate	\$26.13	\$50.08	\$95.38			
TOTALS:		28	22	103		\$139,692	

Product Name	Rate Period	1P Rate	2P Rate	FF Rate	Monthly Composite	Total Cost	Estimated Annual Savings
Guardian Dental 75/75/50/75; \$1500/\$1000	7/1/2020-6/30/2021	\$32.09	\$63.61	\$115.06	\$92.48	\$169,789	-\$30,097
MetLife Dental 75/75/50/75; \$1500/\$1000	7/1/2020-6/30/2021	\$30.89	\$59.34	\$100.88	\$82.10	\$150,732	-\$11,040
SunLife		Solicited and declined to quote					
MESSA		Solicited and did not provide options					

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*Guardian Dental Annual Limits include Maximum Rollover benefit.



Vision Rate Summary
St. Joseph Public Schools
Administration, Secretaries, Transportation and Teachers
Assumed Effective Date: 7/1/2020

Current Plan(s) and Segment:		1P	2P	FF	Monthly Composite	Total Annual Cost	Rate Period
Administration, Secretaries, Transportation and Teachers	Census	31	27	129	\$20.53	\$46,062	1/1/2020-12/31/2020
MESSA Vision VSP 3 \$0/\$0 Copay - \$65 Frame	Rate	\$7.59	\$16.30	\$24.52			
	TOTALS:	31	27	129		\$46,062	

Product Name	Rate Period	1P Rate	2P Rate	FF Rate	Monthly Composite	Total Cost	Estimated Annual Savings
MetLife Vision \$0/\$0 Copay - \$65 Frame	7/1/2020-6/30/2022	\$7.10	\$13.34	\$19.01	\$16.22	\$36,391	\$9,671
Guardian Vision \$0/\$0 Copay -\$130 Frame	7/1/2020-6/30/2022	\$10.34	\$15.69	\$27.58	\$23.01	\$51,624	-\$5,562
EyeMed Vision \$0/\$ Copay - \$65 Frame	7/1/2020-6/30/2024	\$6.62	\$12.58	\$18.48	\$15.66	\$35,146	\$10,916
SunLife		Solicited and declined to quote					
MESSA		Solicited and did not provide options					

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*All proposed options, frames are in-lieu of contacts.



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Vision Plan Comparison

St. Joseph Public Schools

Administration, Secretaries, Transportation and Teachers

CURRENT PLAN

Option 1

Name	Administration, Secretaries, Transportation and Teachers		EyeMed Vision \$0/\$ Copay - \$65 Frame	
	MESSA Vision VSP 3 \$0/\$0 Copay \$65 Frame			
Rate Period	1/1/2020-12/31/2020		7/1/2020-6/30/2024	
Purchased Plan Features	Coverage Allowance		Coverage Allowance	
Optometrist Exam	100% Coverage after \$0 Copay		100% Coverage after \$0 Copay	
Ophthalmologist Exam	100% Coverage after \$0 Copay		100% Coverage after \$0 Copay	
Regular Lenses	100% Coverage after \$0 Copay		100% Coverage after \$0 Copay	
Bifocal Lenses	100% Coverage after \$0 Copay		100% Coverage after \$0 Copay	
Trifocal Lenses	100% Coverage after \$0 Copay		100% Coverage after \$0 Copay	
Lenticular Lenses	100% Coverage after \$0 Copay		100% Coverage after \$0 Copay	
Frame Allowance	\$65.00 once every 12 months		\$65.00 once every 12 months	
Necessary Contacts	100% once every 12 months		100% once every 12 months	
Cosmetic Contacts	\$115.00 once every 12 months		\$115.00 once every 12 months	
Exam Copay	\$0		\$0	
Material Copay	\$0		\$0	
Purchased Plan Rates	Census	Rates	Census	Rates
One Person (1P)	31	\$7.59	31	\$6.62
Two Person (2P)	27	\$16.30	27	\$12.58
Family (FF)	129	\$24.52	129	\$18.48
Total Annual Premium	187	\$46,062	187	\$35,146
Estimated Cost for Benefit Increase \$			\$5	\$10,916
Estimated Savings - %				24%

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Vision Rate Summary
St. Joseph Public Schools
Maintenance
Assumed Effective Date: 7/1/2020

Current Plan(s) and Segment:		1P	2P	FF	Monthly Composite	Total Annual Cost	Rate Period
Maintenance	Census	3	4	4	\$8.31	\$1,097	1/1/2020-12/31/2020
MESSA Vision VSP 1 \$10/\$25 Copay - \$65 Frame	Rate	\$3.73	\$8.01	\$12.05			
	TOTALS:	3	4	4		\$1,097	

Product Name	Rate Period	1P Rate	2P Rate	FF Rate	Monthly Composite	Total Cost	Estimated Annual Savings
MetLife Vision \$10/\$10 Copay - \$65 Frame	7/1/2020-6/30/2022	\$4.91	\$9.23	\$13.13	\$9.47	\$1,250	-\$153
Guardian Vision \$10/\$25 Copay -\$130 Frame	7/1/2020-6/30/2022	\$7.39	\$11.21	\$19.70	\$13.26	\$1,750	-\$653
EyeMed Vision \$6/\$18 Copay - \$65 Frame	7/1/2020-6/30/2024	\$4.80	\$9.12	\$13.40	\$9.50	\$1,254	-\$157
SunLife		Solicited and declined to quote					
MESSA		Solicited and did not provide options					

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Vision Plan Comparison

St. Joseph Public Schools Maintenance

	CURRENT PLAN		Option 1	
Name	Maintenance			
Rate Period	MESSA Vision VSP 1 \$10/\$25 Copay - \$65		EyeMed Vision \$6/\$18 Copay - \$65 Frame	
Purchased Plan Features	Frame		Frame	
Purchased Plan Features	Coverage Allowance		Coverage Allowance	
Optometrist Exam	100% Coverage after \$10 Copay		100% Coverage after \$6 Copay	
Ophthalmologist Exam	100% Coverage after \$10 Copay		100% Coverage after \$6 Copay	
Regular Lenses	100% Coverage after \$25 Copay		100% Coverage after \$18 Copay	
Bifocal Lenses	100% Coverage after \$25 Copay		100% Coverage after \$18 Copay	
Trifocal Lenses	100% Coverage after \$25 Copay		100% Coverage after \$18 Copay	
Lenticular Lenses	100% Coverage after \$25 Copay		100% Coverage after \$18 Copay	
Frame Allowance	\$65.00 once every 12 months after \$25 Copay		\$65.00 once every 12 months	
Necessary Contacts	\$65.00 once every 12 months after \$25 Copay		100% once every 12 months	
Cosmetic Contacts	\$65.00 once every 12 months after \$25 Copay		\$90.00 once every 12 months	
Exam Copay	\$10		\$6	
Material Copay	\$25		\$18	
Purchased Plan Rates	Census	Rates	Census	Rates
One Person (1P)	3	\$3.73	3	\$4.80
Two Person (2P)	4	\$8.01	4	\$9.12
Family (FF)	4	\$12.05	4	\$13.40
Total Annual Premium	11	\$1,097	11	\$1,254
Estimated Cost for Benefit Increase - \$			-\$1	-\$157
Estimated Savings - %			-14%	

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