PriorityHealth

Rate Exhibit

Employer Group	Traverse City Area Public Schools - June
Product	POS
Rate Period	2nd Quarter 2010 Estimated
Effective Date	6/1/2010
Rating Segment	Maintenance Only In Area
Agent	Direct - No Agent
Agent Commission	0.00% commission

Notes: Short Plan Year Eff 7/1/2010 through 5/31/2011

Plan Components

Base Plan

POS #3 100% Preferred / 70% Alternate Coinsurance

Office Visit

Copay Alignment - $20 Primary / $35 Specialist / $50 Urgent Care / $150 Imaging Copay

Medical Deductible

$100 Individual / $300 Family Preferred Medical Deductible

Out-of-Pocket Maximum

Preferred Out-of-Pocket N/A - POS 1, 2, 3, or 7

Rx Copay

3-Tier Rx with Specialty - $10 Generic / $60 Preferred Brand / $80 Non-Preferred Brand / 20% Preferred Specialty $150 Max / 20% Non-Preferred Specialty $300 Max Rx Copay Including Contraceptives, mail-order 2x retail copay

Rx Deductible

No Rx Deductible

Rx Miscellaneous

Mail-order Rx - 90 Day Supply at 1 Times Copay

Emergency Room

Emergency Room $100 Copay

Ambulance

Ambulance $50 Copay

DME

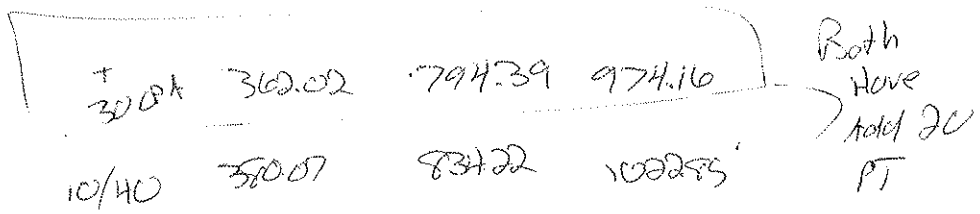
Durable Medical Equipment 20% Copay

Dependent Child Continuation

Dependent Child Continuation - POS 3

P\&O

Prosthetics \& Orthotics 20% Copay



Alternate Medical Deductible

$250 Individual / $500 Family Alternate Medical Deductible

Alternate Out-of-Pocket Maximum

$2,500 Individual / $5,000 Family Maximum Alternate Out-of-Pocket - POS 3

Alternate Lifetime Maximum

Alternate $1 Million Lifetime Maximum

Hospital Copay per Out-of-Network Admit

No Additional Hospital Copay per Out-of-Network Admit

	Single	Double	Family	Spons Dep
Totals	$367.41	$806.29	$988.70	$440.90
Participants	27	25	19	

Summary

Participants	**71**
Monthly Cost	**$48,862.53**
Annual Cost	**$586,350.33**
PEPM	**$688.20**

Notes:

1. Final premium rates will vary slightly due to rounding.

2. Rates and benefits may be pending and subject to approval by the Michigan Office of Financial and Insurance Regulation.
3. All released quotes are based on enrollment provided by the group or agent (proposals) or extracted from the Priority Health system (renewals). Re-rating, including stop-loss premiums and attachment points, may be required if actual enrollment as of the effective date differs by 10% or more.
4. Priority Health's POS plans may not coexist with other carriers.
5. If two Priority Health plan designs coexist, there must be two or more differences in preferred base coinsurance, deductible, office visit copay, and/or Rx copay. 5 or more must enroll in each offered plan design.

Other restrictions apply. Please contact your Priority Health Sales Representative for plan design approval and actual rates prior to finalizing the proposal or renewal. Priority Health is not liable for agent or employer group errors.

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Rating Segment	**Maintenance Only In Area**
Agent	**Direct - No Agent**

Plan Components	Single	Double	Family	PEPM
Base Plan				
POS #1 100% Preferred / 80% Alternate Coinsurance	$348.51	$768.78	$939.89	$654.75
POS #2 100% Preferred / 75% Alternate Coinsurance	$345.68	$762.54	$932.26	$649.43
POS #3 100% Preferred / 70% Alternate Coinsurance	$343.34	$757.38	$925.95	$645.04
POS #4 90% Preferred / 70% Alternate Coinsurance	$331.66	$731.61	$894.45	$623.10
POS #6 80% Preferred / 60% Alternate Coinsurance	$318.99	$703.66	$860.27	$599.29
POS #7 100% Preferred / 50% Alternate Coinsurance	$339.45	$748.80	$915.46	$637.73
Office Visit				
$0 Office Visit Copay	$11.69	$25.79	$31.53	$21.96
$5 Office Visit Copay	$5.68	$12.52	$15.31	$10.66
$10 Office Visit Copay	$0.00	$0.00	$0.00	$0.00
$15 Office Visit Copay	($4.51)	($9.95)	($12.17)	($8.48)
$20 Office Visit Copay	($8.04)	($17.73)	($21.68)	($15.10)
$25 Office Visit Copay	($11.81)	($26.06)	($31.86)	($22.20)
$30 Office Visit Copay	($15.12)	($33.34)	($40.77)	($28.40)
$10 Office Visit / $20 Urgent Care Copay	($0.34)	($0.75)	($0.91)	($0.64)
$15 Office Visit / $25 Urgent Care Copay	($4.79)	($10.57)	($12.93)	($9.01)
$20 Office Visit / $30 Urgent Care Copay	($8.32)	($18.36)	($22.44)	($15.63)
$25 Office Visit / $35 Urgent Care Copay	($12.07)	($26.64)	($32.56)	($22.69)
$30 Office Visit / $40 Urgent Care Copay	($15.36)	($33.89)	($41.44)	($28.87)
Copay Alignment - $10 Primary / $25 Specialist / $40 Urgent Care / $150 Imaging Copay	($9.18)	($20.25)	($24.76)	($17.25)
Copay Alignment - $15 Primary / $30 Specialist / $45 Urgent Care / $150 Imaging Copay	($12.99)	($28.66)	($35.03)	($24.41)
Copay Alignment - $20 Primary / $35 Specialist / $50 Urgent Care / $150 Imaging Copay	($16.35)	($36.06)	($44.09)	($30.71)
Copay Alignment - $25 Primary / $40 Specialist / $55 Urgent Care / $150 Imaging Copay	($20.97)	($46.26)	($56.56)	($39.40)
Copay Alignment - $30 Primary / $45 Specialist / $60 Urgent Care / $150 Imaging Copay	($22.78)	($50.25)	($61.44)	($42.80)
Preventive Care				
$0 Preventive Care Copay - $5 PCP	$1.29	$2.84	$3.48	$2.42
$0 Preventive Care Copay - $10 PCP	$2.51	$5.54	$6.77	$4.72
$0 Preventive Care Copay - $15 PCP	$3.48	$7.68	$9.39	$6.54
$0 Preventive Care Copay - $20 PCP	$4.25	$9.38	$11.46	$7.99
$0 Preventive Care Copay - $25 PCP	$5.07	$11.17	$13.66	$9.52
$0 Preventive Care Copay - $30 PCP	$5.78	$12.74	$15.58	$10.85

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Plan Components	Single	Double	Family	PEPM
Medical Deductible				
No Preferred Medical Deductible	$0.00	$0.00	$0.00	$0.00
$100 Individual / $200 Family Preferred Medical Deductible	($5.05)	($11.15)	($13.63)	($9.49)
$100 Individual / $300 Family Preferred Medical Deductible	($7.08)	($19.80)	($21.25)	($15.35)
$250 Individual / $500 Family Preferred Medical Deductible	($13.76)	($30.35)	($35.42)	($25.40)
$500 Individual / $1,000 Family Preferred Medical Deductible	($28.64)	($63.17)	($70.83)	($52.09)
$750 Individual / $1,500 Family Preferred Medical Deductible	($40.11)	($88.49)	($106.25)	($74.85)
$1,000 Individual / $2,000 Family Preferred Medical Deductible	($55.25)	($121.88)	($141.67)	($101.84)
$1,500 Individual / $3,000 Family Preferred Medical Deductible	($65.35)	($144.15)	($176.24)	($122.77)
$2,000 Individual / $4,000 Family Preferred Medical Deductible	($72.99)	($161.01)	($196.85)	($137.13)
$2,500 Individual / $5,000 Family Preferred Medical Deductible	($83.68)	($184.58)	($225.66)	($157.20)
$3,000 Individual / $6,000 Family Preferred Medical Deductible	($93.84)	($207.00)	($253.08)	($176.30)
$4,000 Individual / $8,000 Family Preferred Medical Deductible	($107.64)	($237.45)	($290.30)	($202.23)
$5,000 Individual / $10,000 Family Preferred Medical Deductible	($119.05)	($262.62)	($321.07)	($223.66)
Out-of-Pocket Maximum				
Preferred Out-of-Pocket N/A - POS 1, 2, 3, or 7	$0.00	$0.00	$0.00	$0.00
$500 Individual / $1,000 Family Maximum Preferred Out-of-Pocket - POS 4	$1.89	$4.17	$5.09	$3.55
$500 Individual / $1,500 Family Maximum Preferred Out-of-Pocket - POS 4	$0.96	$2.12	$2.59	$1.81
$800 Individual / $1,600 Family Maximum Preferred Out-of-Pocket - POS 4	$0.58	$1.27	$1.56	$1.08
$1,000 Individual / $2,000 Family Maximum Preferred Out-of-Pocket - POS 4	$0.00	$0.00	$0.00	$0.00
$1,500 Individual / $3,000 Family Maximum Preferred Out-of-Pocket - POS 4	($0.94)	($2.07)	($2.53)	($1.76)
$2,000 Individual / $4,000 Family Maximum Preferred Out-of-Pocket - POS 4	($1.50)	($3.32)	($4.06)	($2.83)
$2,500 Individual / $5,000 Family Maximum Preferred Out-of-Pocket - POS 4	($1.89)	($4.17)	($5.09)	($3.55)
$500 Individual / $1,000 Family Maximum Preferred Out-of-Pocket - POS 6	$6.21	$13.69	$16.74	$11.66
$800 Individual / $1,600 Family Maximum Preferred Out-of-Pocket - POS 6	$3.54	$7.81	$9.54	$6.65
$800 Individual / $2,400 Family Maximum Preferred Out-of-Pocket - POS 6	$1.61	$3.54	$4.33	$3.02
$1,000 Individual / $2,000 Family Maximum Preferred Out-of-Pocket - POS 6	$2.24	$4.94	$6.04	$4.21
$1,500 Individual / $3,000 Family Maximum Preferred Out-of-Pocket - POS 6	$0.00	$0.00	$0.00	$0.00
$2,000 Individual / $4,000 Family Maximum Preferred Out-of-Pocket - POS 6	($1.46)	($3.22)	($3.93)	($2.74)
$2,500 Individual / $5,000 Family Maximum Preferred Out-of-Pocket - POS 6	($2.50)	($5.51)	($6.74)	($4.69)
Rx Copay				
$0 Rx Copay Excluding Contraceptives, mail-order 2x retail copay	$166.40	$367.07	$448.77	$312.62

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Rating Segment	**Maintenance Only In Area**
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Plan Components	Single	Double	Family	PEPM
$3 Rx Copay Excluding Contraceptives, mail-order 2x retail copay	$142.75	$314.89	$384.98	$268.19
$4 Rx Copay Excluding Contraceptives, mail-order 2x retail copay	$136.59	$301.30	$368.36	$256.61
$5 Rx Copay Excluding Contraceptives, mail-order 2x retail copay	$130.95	$288.86	$353.15	$246.01
$7 Rx Copay Excluding Contraceptives, mail-order 2x retail copay	$117.02	$258.13	$315.58	$219.84
$10 Rx Copay Excluding Contraceptives, mail-order 2x retail copay	$92.34	$203.69	$249.02	$173.47
$15 Rx Copay Excluding Contraceptives, mail-order 2x retail copay	$75.28	$166.05	$203.01	$141.42
$20 Rx Copay Excluding Contraceptives, mail-order 2x retail copay	$60.50	$133.45	$163.16	$113.66
$25 Rx Copay Excluding Contraceptives, mail-order 2x retail copay	$56.73	$125.15	$153.00	$106.59
50% Rx Copay Excluding Contraceptives, mail-order 1x retail copay	$30.05	$66.29	$81.05	$56.46
25% Rx Excluding Contraceptives, $50 Max Out-of-Pocket per Script, mail-order 1x retail copay	$58.73	$129.56	$158.40	$110.35
50% Rx Excluding Contraceptives, $50 Max Out-of-Pocket per Script, mail-order 1x retail copay	$38.27	$84.42	$103.21	$71.90
25% Rx Excluding Contraceptives, $1,000 Annual Max Out-of-Pocket, mail-order 1x retail copay	$59.81	$131.93	$161.30	$112.36
$5 Generic / $10 Brand Rx Copay Excluding Contraceptives, mail-order 2x retail copay	$109.44	$241.42	$295.15	$205.61
$5 Generic / $15 Brand Rx Copay Excluding Contraceptives, mail-order 2x retail copay	$88.58	$195.40	$238.90	$166.42
$7.50 Generic / $15 Brand Rx Copay Excluding Contraceptives, mail-order 2x retail copay	$84.14	$185.60	$226.91	$158.07
$10 Generic / $20 Brand Rx Copay Excluding Contraceptives, mail-order 2x retail copay	$69.12	$152.48	$186.42	$129.87
$10 Generic / $25 Brand Rx Copay Excluding Contraceptives, mail-order 2x retail copay	$62.31	$137.44	$168.04	$117.06
$10 Generic / $30 Brand Rx Copay Excluding Contraceptives, mail-order 2x retail copay	$57.15	$126.07	$154.13	$107.37
$10 Generic / $40 Brand Rx Copay Excluding Contraceptives, mail-order 2x retail copay	$46.52	$102.63	$125.47	$87.41
$10 Generic / $50 Brand Rx Copay Excluding Contraceptives, mail-order 2x retail copay	$42.68	$94.15	$115.10	$80.18
$15 Generic / $25 Brand Rx Copay Excluding Contraceptives, mail-order 2x retail copay	$59.06	$130.29	$159.29	$110.96
$15 Generic / $30 Brand Rx Copay Excluding Contraceptives, mail-order 2x retail copay	$54.17	$119.49	$146.08	$101.76
$15 Generic / $50 Brand Rx Copay Excluding Contraceptives, mail-order 2x retail copay	$39.72	$87.61	$107.11	$74.62
$10 Generic / $20 Brand / $40 Non-Formulary - Closed Rx Copay Excluding Contraceptives, mail-order 2x retail copay	$66.67	$147.07	$179.81	$125.26
$10 Generic / $20 Brand / $40 Non-Formulary - Open Rx Copay Excluding Contraceptives, mail-order 2x retail copay	$78.98	$174.23	$213.01	$148.39
$10 Generic / $20 Brand / 50% Non-Formulary - Open Rx Copay Excluding Contraceptives, mail-order 2x retail copay	$74.33	$163.96	$200.45	$139.64
3-Tier Rx with Specialty - $10 Generic / $30 Preferred Brand / $60 Non-Preferred Brand / 20% Preferred Specialty $100 Max / 20% Non-Preferred Specialty $200 Max Rx Copay Excluding Contraceptives, mail-order 2x retail copay	$53.22	$117.39	$143.52	$99.98

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Plan Components	**Single**	**Double**	**Family**	**PEPM**
3-Tier Rx with Specialty - $10 Generic / $40 Preferred Brand / $80 Non-Preferred Brand / 20% Preferred Specialty $100 Max / 20% Non-Preferred Specialty $200 Max Rx Copay Excluding Contraceptives, mail-order 2x retail copay	$43.84	$96.72	$118.24	$82.37
3-Tier Rx with Specialty - $10 Generic / $60 Preferred Brand / $80 Non-Preferred Brand / 20% Preferred Specialty $150 Max / 20% Non-Preferred Specialty $300 Max Rx Copay Excluding Contraceptives, mail-order 2x retail copay	$32.22	$71.08	$86.90	$60.54
3-Tier Rx with Specialty - $15 Generic / $30 Preferred Brand / $60 Non-Preferred Brand / 20% Preferred Specialty $100 Max / 20% Non-Preferred Specialty $200 Max Rx Copay Excluding Contraceptives, mail-order 2x retail copay	$51.19	$112.93	$138.06	$96.18
3-Tier Rx with Specialty - $15 Generic / $50 Preferred Brand / $80 Non-Preferred Brand / 20% Preferred Specialty $150 Max / 20% Non-Preferred Specialty $300 Max Rx Copay Excluding Contraceptives, mail-order 2x retail copay	$34.91	$77.01	$94.16	$65.59
3-Tier Rx with Specialty - $20 Generic / $60 Preferred Brand / $80 Non-Preferred Brand / 20% Preferred Specialty $200 Max / 20% Non-Preferred Specialty $400 Max Rx Copay Excluding Contraceptives, mail-order 2x retail copay	$29.55	$65.19	$79.70	$55.52
$0 Rx Copay Including Contraceptives, mail-order 2x retail copay	$169.50	$373.90	$457.12	$318.44
$3 Rx Copay Including Contraceptives, mail-order 2x retail copay	$145.67	$321.33	$392.85	$273.67
$4 Rx Copay Including Contraceptives, mail-order 2x retail copay	$139.46	$307.63	$376.11	$262.00
$5 Rx Copay Including Contraceptives, mail-order 2x retail copay	$133.76	$295.07	$360.74	$251.30
$7 Rx Copay Including Contraceptives, mail-order 2x retail copay	$119.72	$264.09	$322.87	$224.92
$10 Rx Copay Including Contraceptives, mail-order 2x retail copay	$94.87	$209.27	$255.85	$178.23
$15 Rx Copay Including Contraceptives, mail-order 2x retail copay	$77.49	$170.94	$208.99	$145.58
$20 Rx Copay Including Contraceptives, mail-order 2x retail copay	$61.78	$136.27	$166.60	$116.06
$25 Rx Copay Including Contraceptives, mail-order 2x retail copay	$57.90	$127.72	$156.14	$108.77
50% Rx Copay Including Contraceptives, mail-order 1x retail copay	$31.60	$69.71	$85.22	$59.37
25% Rx Including Contraceptives, $50 Maximum Out-of-Pocket per Script, mail-order 1x retail copay	$60.69	$133.88	$163.68	$114.02
50% Rx Including Contraceptives, $50 Maximum Out-of-Pocket per Script, mail-order 1x retail copay	$39.37	$86.84	$106.17	$73.96

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Plan Components	**Single**	**Double**	**Family**	**PEPM**
25% Rx Including Contraceptives, $1,000 Annual Maximum Out-of-Pocket, mail-order 1x retail copay	$61.80	$136.32	$166.66	$116.10
$5 Generic / $10 Brand Rx Copay Including Contraceptives, mail-order 2x retail copay	$112.14	$247.38	$302.44	$210.69
$5 Generic / $15 Brand Rx Copay Including Contraceptives, mail-order 2x retail copay	$91.17	$201.12	$245.88	$171.29
$7.50 Generic / $15 Brand Rx Copay Including Contraceptives, mail-order 2x retail copay	$86.64	$191.12	$233.65	$162.77
$10 Generic / $20 Brand Rx Copay Including Contraceptives, mail-order 2x retail copay	$71.42	$157.55	$192.61	$134.18
$10 Generic / $25 Brand Rx Copay Including Contraceptives, mail-order 2x retail copay	$63.89	$140.94	$172.30	$120.03
$10 Generic / $30 Brand Rx Copay Including Contraceptives, mail-order 2x retail copay	$59.75	$131.81	$161.14	$112.26
$10 Generic / $40 Brand Rx Copay Including Contraceptives, mail-order 2x retail copay	$48.89	$107.84	$131.84	$91.84
$10 Generic / $50 Brand Rx Copay Including Contraceptives, mail-order 2x retail copay	$44.24	$97.59	$119.31	$83.11
$15 Generic / $25 Brand Rx Copay Including Contraceptives, mail-order 2x retail copay	$60.41	$133.25	$162.91	$113.49
$15 Generic / $30 Brand Rx Copay Including Contraceptives, mail-order 2x retail copay	$56.52	$124.68	$152.42	$106.18
$15 Generic / $50 Brand Rx Copay Including Contraceptives, mail-order 2x retail copay	$40.76	$89.91	$109.92	$76.57
$10 Generic / $20 Brand / $40 Non-Formulary - Closed Rx Copay Including Contraceptives, mail-order 2x retail copay	$68.38	$150.84	$184.41	$128.46
$10 Generic / $20 Brand / $40 Non-Formulary - Open Rx Copay Including Contraceptives, mail-order 2x retail copay	$80.83	$178.30	$217.98	$151.85
$10 Generic / $20 Brand / 50% Non-Formulary - Open Rx Copay Including Contraceptives, mail-order 2x retail copay	$76.09	$167.85	$205.20	$142.95
3-Tier Rx with Specialty - $10 Generic / $30 Preferred Brand / $60 Non-Preferred Brand / 20% Preferred Specialty $100 Max / 20% Non-Preferred Specialty $200 Max Rx Copay Including Contraceptives, mail-order 2x retail copay	$54.49	$120.21	$146.97	$102.38
3-Tier Rx with Specialty - $10 Generic / $40 Preferred Brand / $80 Non-Preferred Brand / 20% Preferred Specialty $100 Max / 20% Non-Preferred Specialty $200 Max Rx Copay Including Contraceptives, mail-order 2x retail copay	$44.96	$99.19	$121.26	$84.47
3-Tier Rx with Specialty - $10 Generic / $60 Preferred Brand / $80 Non-Preferred Brand / 20% Preferred Specialty $150 Max / 20% Non-Preferred Specialty $300 Max Rx Copay Including Contraceptives, mail-order 2x retail copay	$33.13	$73.07	$89.34	$62.24
3-Tier Rx with Specialty - $15 Generic / $30 Preferred Brand / $60 Non-Preferred Brand / 20% Preferred Specialty $100 Max / 20% Non-Preferred Specialty $200 Max Rx Copay Including Contraceptives, mail-order 2x retail copay	$53.00	$116.92	$142.94	$99.58

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Plan Components	**Single**	**Double**	**Family**	**PEPM**
3-Tier Rx with Specialty - $15 Generic / $50 Preferred Brand / $80 Non-Preferred Brand / 20% Preferred Specialty $150 Max / 20% Non-Preferred Specialty $300 Max Rx Copay Including Contraceptives, mail-order 2x retail copay	$35.75	$78.86	$96.41	$67.16
3-Tier Rx with Specialty - $20 Generic / $60 Preferred Brand / $80 Non-Preferred Brand / 20% Preferred Specialty $200 Max / 20% Non-Preferred Specialty $400 Max Rx Copay Including Contraceptives, mail-order 2x retail copay	$30.19	$66.59	$81.41	$56.71
Rx Deductible				
No Rx Deductible	$0.00	$0.00	$0.00	$0.00
$100 Individual / $200 Family Rx Deductible - Generic \& Brand Drugs	($4.99)	($11.00)	($13.45)	($9.37)
$200 Individual / $400 Family Rx Deductible - Generic \& Brand Drugs	($9.44)	($20.82)	($25.46)	($17.74)
$100 Individual / $200 Family Rx Deductible - Brand Drugs only	($2.70)	($5.96)	($7.29)	($5.08)
$200 Individual / $400 Family Rx Deductible - Brand Drugs only	($5.10)	($11.25)	($13.75)	($9.58)
Rx Non-Formulary				
50% Non-Formulary - Closed Rx Copay	($2.37)	($5.24)	($6.40)	($4.46)
$50 Non-Formulary - Closed Rx Copay	($1.87)	($4.12)	($5.03)	($3.50)
50% Non-Formulary - Open Rx Copay	$4.30	$9.48	$11.59	$8.07
$50 Non-Formulary - Open Rx Copay	$5.09	$11.22	$13.72	$9.56
Rx Sexual Dysfunction				
Oral \& Non-Oral Treatment for Sexual Dysfunction 50% Copay	$0.71	$1.57	$1.92	$1.34
Non-Oral Treatment for Sexual Dysfunction 50% Copay	$0.05	$0.10	$0.12	$0.09
Oral \& Non-Oral Treatment for Sexual Dysfunction - Match Rx Copay	$1.16	$2.57	$3.14	$2.19
Non-Oral Treatment for Sexual Dysfunction - Match Rx Copay	$0.08	$0.17	$0.21	$0.15
Rx Miscellaneous				
Mail-order Rx - 90 Day Supply at 1 Times Copay	$3.17	$6.98	$8.54	$5.95
Mail-order Rx - 90 Day Supply at 2.5 Times Copay	($1.65)	($3.64)	($4.45)	($3.10)
Rx Maximum Copay per Script 50% of Total Cost	$1.89	$4.17	$5.09	$3.55
Infertility Drug Exclusion	($0.10)	($0.22)	($0.27)	($0.19)
Post-Coital Contraceptive Drug Exclusion	$0.00	$0.00	$0.00	$0.00
Emergency Room				
Emergency Room $0 Copay	$2.40	$5.29	$6.46	$4.50

Rate Grid

Employer Group	**Traverse City Area Public Schools - June**
Product	**POS**
Rate Period	**2nd Quarter 2010 Estimated**
Effective Date	**6/1/2010**
Rating Segment	**Maintenance Only In Area**
Agent	**Direct - No Agent**

	Single	Double	Family	PEPM
Plan Components				
Emergency Room $25 Copay	$1.16	$2.57	$3.14	$2.19
Emergency Room $35 Copay	$0.69	$1.52	$1.86	$1.30
Emergency Room $50 Copay	$0.00	$0.00	$0.00	$0.00
Emergency Room $75 Copay	($1.11)	($2.44)	($2.99)	($2.08)
Emergency Room $100 Copay	($2.15)	($4.74)	($5.79)	($4.04)
Emergency Room $150 Copay	($4.04)	($8.90)	($10.89)	($7.58)
Ambulance				
Ambulance $0 Copay	$0.40	$0.87	$1.07	$0.74
Ambulance $25 Copay	$0.18	$0.40	$0.49	$0.34
Ambulance $35 Copay	$0.11	$0.25	$0.30	$0.21
Ambulance $50 Copay	$0.00	$0.00	$0.00	$0.00
Ambulance $75 Copay	($0.17)	($0.37)	($0.46)	($0.32)
Ambulance $100 Copay	($0.36)	($0.80)	($0.98)	($0.68)
DME				
Durable Medical Equipment 0% Copay	$4.90	$10.80	$13.20	$9.20
Durable Medical Equipment 10% Copay	$3.86	$8.50	$10.40	$7.24
Durable Medical Equipment 20% Copay	$2.88	$6.36	$7.78	$5.42
Durable Medical Equipment 50% Copay	$0.00	$0.00	$0.00	$0.00
P\&O				
Prosthetics \& Orthotics 0% Copay	$0.77	$1.70	$2.07	$1.44
Prosthetics \& Orthotics 10% Copay	$0.62	$1.37	$1.68	$1.17
Prosthetics \& Orthotics 20% Copay	$0.47	$1.05	$1.28	$0.89
Prosthetics \& Orthotics 50% Copay	$0.00	$0.00	$0.00	$0.00
Dependent Child Continuation				
Dependent Child Continuation - POS 1	$10.46	$23.07	$28.20	$19.65
Dependent Child Continuation - POS 2	$10.37	$22.87	$27.96	$19.48
Dependent Child Continuation - POS 3	$10.30	$22.72	$27.78	$19.35
Dependent Child Continuation - POS 4	$9.95	$21.95	$26.83	$18.69
Dependent Child Continuation - POS 6	$9.56	$21.10	$25.80	$17.97
Dependent Child Continuation - POS 7	$10.19	$22.47	$27.47	$19.14
Full-Time Student Exclusion				
Full-Time Student Exclusion - POS 1	($3.66)	($8.08)	($9.88)	($6.88)

PriorityHealth

Rate Grid

Employer Group	**Traverse City Area Public Schools - June**
Product	**POS**
Rate Period	**2nd Quarter 2010 Estimated**
Effective Date	**6/1/2010**
Rating Segment	**Maintenance Only In Area**
Agent	**Direct - No Agent**

Plan Components	Single	Double	Family	PEPM
Full-Time Student Exclusion - POS 2	($3.63)	($8.01)	($9.79)	($6.82)
Full-Time Student Exclusion - POS 3	($3.61)	($7.96)	($9.73)	($6.78)
Full-Time Student Exclusion - POS 4	($3.48)	($7.68)	($9.39)	($6.54)
Full-Time Student Exclusion - POS 6	($3.35)	($7.38)	($9.03)	($6.29)
Full-Time Student Exclusion - POS 7	($3.56)	($7.86)	($9.60)	($6.69)
IP Mental Health - Additional Days				
Inpatient Mental Health - 10 Additional Days 0% Coinsurance - POS 1, 2, 3, or 7	$0.96	$2.12	$2.59	$1.81
Inpatient Mental Health - 10 Additional Days 10% Coinsurance - POS 4	$0.86	$1.90	$2.32	$1.61
Inpatient Mental Health - 10 Additional Days 20% Coinsurance - POS 6	$0.77	$1.70	$2.07	$1.44
Inpatient Mental Health - 25 Additional Days 0% Coinsurance - POS 1, 2, 3, or 7	$2.40	$5.29	$6.46	$4.50
Inpatient Mental Health - 25 Additional Days 10% Coinsurance - POS 4	$2.16	$4.76	$5.82	$4.06
Inpatient Mental Health - 25 Additional Days 20% Coinsurance - POS 6	$1.91	$4.21	$5.15	$3.59
OP Mental Health - Additional Visits				
Outpatient Mental Health - 10 Additional Visits	$0.12	$0.27	$0.34	$0.23
Outpatient Mental Health - 15 Additional Visits	$0.18	$0.40	$0.49	$0.34
OP Mental Health - Copay				
Outpatient Mental Health $0 Copay	$1.11	$2.44	$2.99	$2.08
Outpatient Mental Health $10 Copay	$0.53	$1.17	$1.43	$1.00
Outpatient Mental Health $15 Copay	$0.24	$0.52	$0.64	$0.45
Outpatient Mental Health $30 Copay	($0.36)	($0.80)	($0.98)	($0.68)
Mental Health - Wellness				
Mental Health - Add Wellness Coverage	$1.19	$2.62	$3.20	$2.23
IP/OP Substance Abuse - Copay				
Substance Abuse $0 Copay	$4.62	$10.20	$12.47	$8.69
Substance Abuse $0 Copay Inpatient, $10 Copay Outpatient	$4.58	$10.10	$12.35	$8.60
IP Substance Abuse - Days				
Inpatient Substance Abuse - 30 Days	$1.92	$4.24	$5.18	$3.61
Inpatient Substance Abuse - 45 Days	$2.40	$5.29	$6.46	$4.50
Substance Abuse Miscellaneous				
Inpatient Substance Abuse - 50% Coinsurance	($0.02)	($0.05)	($0.06)	($0.04)
Outpatient Substance Abuse - 35 Visits	$0.08	$0.17	$0.21	$0.15
Outpatient Substance Abuse $20 Copay	$0.00	$0.00	$0.00	$0.00

Rate Grid

Employer Group	**Traverse City Area Public Schools - June**
Product	**POS**
Rate Period	**2nd Quarter 2010 Estimated**
Effective Date	**6/1/2010**
Rating Segment	**Maintenance Only In Area**
Agent	**Direct - No Agent**

	Single	Double	Family	PEPM
Plan Components				
Supplemental Substance Abuse - up to $4,800	$1.37	$3.02	$3.69	$2.57
Vision				
Vision - Exam every two plan years $0 Copay	$0.51	$1.12	$1.37	$0.96
Vision - Exam every one plan year $0 Copay	$1.01	$2.22	$2.71	$1.89
Vision - Exam every one plan year $15 Copay	$0.71	$1.57	$1.92	$1.34
Vision - Exam \& Supplies every two plan years 50% Copay	$1.92	$4.24	$5.18	$3.61
Vision - High Plan, two plan years (Exam \& Supplies)	$3.58	$7.91	$9.67	$6.73
Vision - High Plan, one plan year (Exam \& Supplies)	$7.17	$15.81	$19.33	$13.47
Vision - Value Plan, two plan years (Exam \& Supplies)	$3.53	$7.78	$9.51	$6.63
Vision - Value Plan, one plan year (Exam \& Supplies)	$7.05	$15.56	$19.03	$13.25
Hearing				
Hearing Test and Equipment every three plan years $0 Copay	$1.05	$2.32	$2.84	$1.98
Dental				
Dental Gap	$0.06	$0.12	$0.15	$0.11
Tooth Extraction	$0.99	$2.19	$2.68	$1.87
Rehabilitative Medicine				
Rehabilitative Medicine - 10 Additional Visits	$0.69	$1.52	$1.86	$1.30
Rehabilitative Medicine - 20 Additional Visits	$1.04	$2.29	$2.81	$1.95
Certain Surgeries				
Certain Surgeries Excluding Bariatric	$0.37	$0.82	$1.01	$0.70
Certain Surgeries Including Bariatric	$0.47	$1.05	$1.28	$0.89
Skilled Nursing				
Supplemental Skilled Nursing Facility $0 Copay, 730 Days	$0.60	$1.32	$1.62	$1.13
Skilled Nursing Facility $0 Copay, 120 Days	$0.31	$0.67	$0.82	$0.57
Sterilization				
Sterilization $0 Copay - POS 4	$0.20	$0.45	$0.55	$0.38
Sterilization $0 Copay - POS 6	$0.41	$0.90	$1.10	$0.76
Family Planning				
Infertility $0 Copay	$1.26	$2.77	$3.38	$2.36
Elective First Trimester Termination	$0.35	$0.77	$0.95	$0.66
Hospital Copay per In-Network Admit				
$100 Hospital Copay per In-Network Admit - POS 1	($0.67)	($1.47)	($1.80)	($1.25)

PriorityHealth

Rate Grid

Employer Group	**Traverse City Area Public Schools - June**
Product	**POS**
Rate Period	**2nd Quarter 2010 Estimated**
Effective Date	**6/1/2010**
Rating Segment	**Maintenance Only In Area**
Agent	**Direct - No Agent**

Plan Components	**Single**	**Double**	**Family**	**PEPM**
$100 Hospital Copay per In-Network Admit - POS 2	($0.67)	($1.47)	($1.80)	($1.25)
$100 Hospital Copay per In-Network Admit - POS 3	($0.67)	($1.47)	($1.80)	($1.25)
$100 Hospital Copay per In-Network Admit - POS 7	($0.67)	($1.47)	($1.80)	($1.25)
$250 Hospital Copay per In-Network Admit - POS 1	($1.65)	($3.64)	($4.45)	($3.10)
$250 Hospital Copay per In-Network Admit - POS 2	($1.65)	($3.64)	($4.45)	($3.10)
$250 Hospital Copay per In-Network Admit - POS 3	($1.65)	($3.64)	($4.45)	($3.10)
$250 Hospital Copay per In-Network Admit - POS 7	($1.65)	($3.64)	($4.45)	($3.10)
$500 Hospital Copay per In-Network Admit - POS 1	($3.31)	($7.31)	($8.93)	($6.22)
$500 Hospital Copay per In-Network Admit - POS 2	($3.31)	($7.31)	($8.93)	($6.22)
$500 Hospital Copay per In-Network Admit - POS 3	($3.31)	($7.31)	($8.93)	($6.22)
$500 Hospital Copay per In-Network Admit - POS 7	($3.31)	($7.31)	($8.93)	($6.22)
Alternate Medical Deductible				
No Alternate Medical Deductible	$0.00	$0.00	$0.00	$0.00
$250 Individual / $500 Family Alternate Medical Deductible	($0.77)	($1.70)	($2.07)	($1.44)
$500 Individual / $1,000 Family Alternate Medical Deductible	($1.47)	($3.24)	($3.96)	($2.76)
$1,000 Individual / $2,000 Family Alternate Medical Deductible	($2.67)	($5.89)	($7.20)	($5.01)
$1,500 Individual / $3,000 Family Alternate Medical Deductible	($3.67)	($8.11)	($9.91)	($6.90)
$2,000 Individual / $4,000 Family Alternate Medical Deductible	($5.27)	($11.62)	($14.21)	($9.90)
$2,500 Individual / $5,000 Family Alternate Medical Deductible	($4.52)	($9.98)	($12.20)	($8.50)
$3,000 Individual / $6,000 Family Alternate Medical Deductible	($5.92)	($13.07)	($15.98)	($11.13)
$3,500 Individual / $7,000 Family Alternate Medical Deductible	($6.50)	($14.34)	($17.53)	($12.21)
$4,000 Individual / $8,000 Family Alternate Medical Deductible	($7.02)	($15.49)	($18.93)	($13.19)
$5,000 Individual / $10,000 Family Alternate Medical Deductible	($7.93)	($17.48)	($21.37)	($14.89)
$6,000 Individual / $12,000 Family Alternate Medical Deductible	($8.68)	($19.15)	($23.42)	($16.31)
Alternate Out-of-Pocket Maximum				
$1,000 Individual / $2,000 Family Maximum Alternate Out-of-Pocket - POS 1	$1.66	$3.67	$4.48	$3.12
$1,500 Individual / $3,000 Family Maximum Alternate Out-of-Pocket - POS 1	$0.90	$2.00	$2.44	$1.70
$2,500 Individual / $5,000 Family Maximum Alternate Out-of-Pocket - POS 1	$0.00	$0.00	$0.00	$0.00
$3,000 Individual / $6,000 Family Maximum Alternate Out-of-Pocket - POS 1	($0.28)	($0.62)	($0.76)	($0.53)
$3,500 Individual / $7,000 Family Maximum Alternate Out-of-Pocket - POS 1	($0.51)	($1.12)	($1.37)	($0.96)
$5,000 Individual / $5,000 Family Maximum Alternate Out-of-Pocket - POS 1	($0.20)	($0.45)	($0.55)	($0.38)
$5,000 Individual / $10,000 Family Maximum Alternate Out-of-Pocket - POS 1	($0.97)	($2.14)	($2.62)	($1.83)

PriorityHealth

Rate Grid

Employer Group	**Traverse City Area Public Schools - June**
Product	**POS**
Rate Period	**2nd Quarter 2010 Estimated**
Effective Date	**6/1/2010**
Rating Segment	**Maintenance Only In Area**
Agent	**Direct - No Agent**

Plan Components

	Single	Double	Family	PEPM
$1,000 Individual / $2,000 Family Maximum Alternate Out-of-Pocket - POS 2	$2.09	$4.61	$5.64	$3.93
$1,500 Individual / $3,000 Family Maximum Alternate Out-of-Pocket - POS 2	$1.16	$2.57	$3.14	$2.19
$2,500 Individual / $5,000 Family Maximum Alternate Out-of-Pocket - POS 2	$0.00	$0.00	$0.00	$0.00
$3,000 Individual / $6,000 Family Maximum Alternate Out-of-Pocket - POS 2	($0.38)	($0.85)	($1.04)	($0.72)
$3,500 Individual / $7,000 Family Maximum Alternate Out-of-Pocket - POS 2	($0.68)	($1.50)	($1.83)	($1.27)
$5,000 Individual / $5,000 Family Maximum Alternate Out-of-Pocket - POS 2	($0.26)	($0.57)	($0.70)	($0.49)
$5,000 Individual / $10,000 Family Maximum Alternate Out-of-Pocket - POS 2	($1.31)	($2.89)	($3.54)	($2.46)
$1,000 Individual / $2,000 Family Maximum Alternate Out-of-Pocket - POS 3	$2.46	$5.44	$6.65	$4.63
$1,500 Individual / $3,000 Family Maximum Alternate Out-of-Pocket - POS 3	$1.40	$3.09	$3.78	$2.63
$2,500 Individual / $5,000 Family Maximum Alternate Out-of-Pocket - POS 3	$0.00	$0.00	$0.00	$0.00
$3,000 Individual / $6,000 Family Maximum Alternate Out-of-Pocket - POS 3	($0.47)	($1.05)	($1.28)	($0.89)
$3,500 Individual / $7,000 Family Maximum Alternate Out-of-Pocket - POS 3	($0.86)	($1.90)	($2.32)	($1.61)
$5,000 Individual / $5,000 Family Maximum Alternate Out-of-Pocket - POS 3	($0.32)	($0.70)	($0.85)	($0.59)
$5,000 Individual / $10,000 Family Maximum Alternate Out-of-Pocket - POS 3	($1.65)	($3.64)	($4.45)	($3.10)
$1,000 Individual / $2,000 Family Maximum Alternate Out-of-Pocket - POS 4	$2.46	$5.44	$6.65	$4.63
$1,500 Individual / $3,000 Family Maximum Alternate Out-of-Pocket - POS 4	$1.40	$3.09	$3.78	$2.63
$2,500 Individual / $5,000 Family Maximum Alternate Out-of-Pocket - POS 4	$0.00	$0.00	$0.00	$0.00
$3,000 Individual / $6,000 Family Maximum Alternate Out-of-Pocket - POS 4	($0.47)	($1.05)	($1.28)	($0.89)
$3,500 Individual / $7,000 Family Maximum Alternate Out-of-Pocket - POS 4	($0.86)	($1.90)	($2.32)	($1.61)
$5,000 Individual / $5,000 Family Maximum Alternate Out-of-Pocket - POS 4	($0.32)	($0.70)	($0.85)	($0.59)
$5,000 Individual / $10,000 Family Maximum Alternate Out-of-Pocket - POS 4	($1.65)	($3.64)	($4.45)	($3.10)
$3,000 Individual / $6,000 Family Maximum Alternate Out-of-Pocket - POS 6	$0.00	$0.00	$0.00	$0.00
$3,500 Individual / $7,000 Family Maximum Alternate Out-of-Pocket - POS 6	($0.53)	($1.17)	($1.43)	($1.00)
$5,000 Individual / $5,000 Family Maximum Alternate Out-of-Pocket - POS 6	$0.25	$0.55	$0.67	$0.47
$5,000 Individual / $10,000 Family Maximum Alternate Out-of-Pocket - POS 6	($1.67)	($3.69)	($4.51)	($3.14)
$3,000 Individual / $6,000 Family Maximum Alternate Out-of-Pocket - POS 7	$0.00	$0.00	$0.00	$0.00
$3,500 Individual / $7,000 Family Maximum Alternate Out-of-Pocket - POS 7	($0.67)	($1.47)	($1.80)	($1.25)
$5,000 Individual / $5,000 Family Maximum Alternate Out-of-Pocket - POS 7	$0.32	$0.70	$0.85	$0.59
$5,000 Individual / $10,000 Family Maximum Alternate Out-of-Pocket - POS 7	($2.15)	($4.74)	($5.79)	($4.04)

Alternate Lifetime Maximum

Alternate $500,000 Lifetime Maximum	$0.00	$0.00	$0.00	$0.00
Alternate $1 Million Lifetime Maximum	$0.46	$1.02	$1.25	$0.87

PriorityHealth

Rate Grid

Employer Group	**Traverse City Area Public Schools - June**
Product	**POS**
Rate Period	**2nd Quarter 2010 Estimated**
Effective Date	**6/1/2010**
Rating Segment	**Maintenance Only In Area**
Agent	**Direct - No Agent**

Plan Components	**Single**	**Double**	**Family**	**PEPM**
Hospital Copay per Out-of-Network Admit				
No Additional Hospital Copay per Out-of-Network Admit	$0.00	$0.00	$0.00	$0.00
$100 Hospital Copay per Out-of-Network Admit	($0.35)	($0.77)	($0.95)	($0.66)
$250 Hospital Copay per Out-of-Network Admit	($0.72)	($1.60)	($1.95)	($1.36)
$500 Hospital Copay per Out-of-Network Admit	($1.14)	($2.52)	($3.08)	($2.15)
Participants	27	25	19	71

Notes:

1. Final premium rates will vary slightly due to rounding.
2. Rates and benefits may be pending and subject to approval by the Michigan Office of Financial and Insurance Regulation.

3. All released quotes are based on enrollment provided by the group or agent (proposals) or extracted from the Priority Health system (renewals). Re-rating, including stop-loss premiums and attachment points, may be required if actual enrollment as of the effective date differs by 10% or more.
4. Priority Health's POS plans may not coexist with other carriers.
5. If two Priority Health plan designs coexist, there must be two or more differences in preferred base coinsurance, deductible, office visit copay, and/or Rx copay. 5 or more must enroll in each offered plan design.

Other restrictions apply. Please contact your Priority Health Sales Representative for plan design approval and actual rates prior to finalizing the proposal or renewal. Priority Health is not liable for agent or employer group errors.