SCOTT & WHITE HEALTH PLAN

Now part of Baylor Scott & White Health

City of Killeen Employee Benefits Trust

Renewal Effective:

10/1/2015

(Revised Apr 9, 2015)

SWHP Renewal - Base Plan Actives/Retirees 4-Tier Option	Medical Plan Type: CCPOS; OV/SP: $35 / $60; Coins: 30%; Ded: $2,500; OOP Max: $6,000 Rates*	Pharmacy $10 / $40 / $100 $0 Ded Unlimited Rates*	Plan: 007994 RX50KOPM Total
Single	$385.05	Included in Medical	$385.05
Employee & Spouse	$909.14	Included in Medical	$909.14
Employee & Child(ren)	$555.16	Included in Medical	$555.16
Family	$1,058.40	Included in Medical	$1,058.40

SWHP Renewal - Mid Plan Actives/Retirees 4-Tier Option	Medical Plan Type: CCPOS; OV/SP: $30 / $50; Coins: 20%; Ded: $1,000; OOP Max: $3,000 Rates*	Pharmacy $10 / $30 / $50 $0 Ded Unlimited Rates*	Plan: 007995 RX98KOPM Total
Single	$531.34	Included in Medical	$531.34
Employee & Spouse	$1,277.64	Included in Medical	$1,277.64
Employee & Child(ren)	$780.17	Included in Medical	$780.17
Family	$1,488.43	Included in Medical	$1,488.43

SWHP Renewal - High Plan Actives/Retirees 4-Tier Option	Medical Plan Type: CCPOS; OV/SP: $40 / $60; Coins: 10%; Ded: N/A; OOP Max: $3,000 Rates*	Pharmacy $5 / $25 / $50 $0 Ded Unlimited Rates*	Plan: 007996 RX64KOPM Total
Single	$615.77	Included in Medical	$615.77
Employee & Spouse	$1,453.94	Included in Medical	$1,453.94
Employee & Child(ren)	$887.78	Included in Medical	$887.78
Family	$1,692.57	Included in Medical	$1,692.57

- Broker Commission: 0.00%
- **Above rates include ACA Fees (Transitional Reinsurance Program fee, Patient Centered Outcomes (PCORI) fee, and Insurer Fee).**
- **Above rates assumes benefits are on a calendar year basis and includes calendar year Deductible credit**
- **Above rates are net of Premium Tax.**
- Medical rates include coverage for durable medical equipment, diabetic supplies, and mandated mental health.
- We reserve the right to change any premium rate, including on a retrospective basis, when the terms of the Agreement are changed or our liability has been altered because of a change in state or federal law or a substantive change in the composition of the group.
- **Please review the Summary of Benefits and Coverage (SBC) for a complete description of benefits.**

______ I hereby accept these rates as presented.
______ I hereby accept these rates without the following riders: (use this option if applicable)

Signed: Date:

Name/Title

Please return this proposal with the signed GERA (Group Eligibility Requirements Attachment) to Scott & White Health Plan in the envelope provided. If we do not receive a signed consent, your group will be assigned the rates and benefits as shown in this proposal.

*It is SWHP's understanding that the employer contribution is at least 100% toward the employee-only rate of the Base Plan. This quote assumes that contribution will continue. If the information is incorrect, please provide us with the current contribution strategy.

Marketing Representative: Rebecca Johnson

4/9/2015