

City of Cole Camp
Marketing Results Summary

MEDICAL	RESULT	PREMIUM	% CHANGE	NOTES
Blue Cross Blue Shield of Kansas City	Current	\$67,804.56		Traditional PCB Silver PPO
Blue Cross Blue Shield of Kansas City	Renewal	\$81,817.32	20.67%	Traditional PCB Silver PPO
Blue Cross Blue Shield of Kansas City	H.S.A. Alternative	\$76,176.00	12.35%	Saver Value PCB Bronze
Blue Cross Blue Shield of Kansas City	Composite Rating	\$81,658.80	20.43%	PCB PPO \$4000 (OOPM \$4000)
Blue Cross Blue Shield of Kansas City	Composite Rating	\$70,704.00	4.28%	PCB PPO \$4000 (OOPM \$9100)
Blue Cross Blue Shield of Kansas City	Composite Rating	\$70,704.00	4.28%	PCB BlueSaver PPO H.S.A. \$5000
DENTAL	RESULT	PREMIUM	% CHANGE	NOTES
Principal	Current	\$1,435.56		
Principal	Renewal	\$1,478.52	2.99%	
VISION	RESULT	PREMIUM	% CHANGE	NOTES
Principal	Current	\$1,086.12		
Principal	Renewal	\$1,086.12	0.00%	
LIFE AND AD&D	RESULT	PREMIUM	% CHANGE	NOTES
Principal	Current	\$1,167.60		
Principal	Renewal	\$1,167.60	0.00%	

City of Cole Camp

Effective Date: 06/01/2026

MEDICAL BENEFITS (In Network Only)	Blue Cross Blue Shield of Kansas City Traditional PCB Silver PPO Current	Blue Cross Blue Shield of Kansas City Traditional PCB Silver PPO Renewal	Blue Cross Blue Shield of Kansas City Saver Value PCB Bronze H.S.A. Alternative
NETWORK	Preferred Care Blue	Preferred Care Blue	Preferred Care Blue
DEDUCTIBLE			
Individual	\$3,500	\$3,500	\$6,000
Family	\$7,000	\$7,000	\$12,000
COINSURANCE			
In / Out of Network	70% 50%	70% 50%	50% 40%
INCLUSIVE OOP MAX			
Individual	\$8,150	\$8,150	\$7,500
Family	\$16,300	\$16,300	\$15,000
OFFICE VISIT	\$60	\$60	Deductible then 50% Coinsurance
SPECIALIST	\$100	\$100	Deductible then 50% Coinsurance
URGENT CARE	\$100	\$100	Deductible then 50% Coinsurance
BLUE KC VIRTUAL CARE	No Member Cost Share	No Member Cost Share	No Member Cost Share
EMERGENCY ROOM	Deductible then 30% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance
INPATIENT HOSPITAL	Deductible then 30% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance
OUTPATIENT SURGERY	Deductible then 30% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance
OUTPATIENT RADIOLOGY	Deductible then 30% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance
PRESCRIPTION DRUGS			
Preferred Generic	Up to \$20	Up to \$20	Deductible then 50% Coinsurance
Preferred Brand	\$75	\$75	Deductible then 50% Coinsurance
Non-Preferred	Deductible then 30% Coinsurance	Deductible then 30% Coinsurance	Deductible then 50% Coinsurance
Preferred Specialty	Deductible then 35% Coinsurance	Deductible then 35% Coinsurance	Deductible then 50% Coinsurance
Employee Only	6	6	6
Employee + Spouse			
Employee + Child(ren)			
Family			
RATES			
Based on Age; See Attached			
MONTHLY ANNUAL PREMIUM	\$5,650.38	\$6,818.11	\$6,348.00
% CHANGE	\$67,804.56	\$81,817.32	\$76,176.00
		20.67%	12.35%

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MEDICAL BENEFITS (In Network Only)	Blue Cross Blue Shield of Kansas City PCB PPO \$4000 (OOPM \$4000)	Blue Cross Blue Shield of Kansas City PCB PPO \$4000 (OOPM \$9100)	Blue Cross Blue Shield of Kansas City PCB BlueSaver PPO H.S.A. \$5000
NETWORK	Preferred Care Blue	Preferred Care Blue	Preferred Care Blue
DEDUCTIBLE			
Individual	\$4,000	\$4,000	\$5,000
Family	\$8,000	\$8,000	\$10,000
COINSURANCE			
In / Out of Network	100% 80%	50% 50%	90% 70%
INCLUSIVE OOP MAX			
Individual	\$4,000	\$9,100	\$6,450
Family	\$8,000	\$18,200	\$12,900
OFFICE VISIT	\$35	\$35	Deductible then 10% Coinsurance
SPECIALIST	\$70	\$70	Deductible then 10% Coinsurance
URGENT CARE	\$70	\$70	Deductible then 10% Coinsurance
BLUE KC VIRTUAL CARE	No Member Cost Share	No Member Cost Share	No Member Cost Share
EMERGENCY ROOM	Deductible	\$100 Copay then Deductible then 50% Coinsurance	Deductible then 10% Coinsurance
INPATIENT HOSPITAL	Deductible	Deductible then 50% Coinsurance	Deductible then 10% Coinsurance
OUTPATIENT SURGERY	Deductible	Deductible then 50% Coinsurance	Deductible then 10% Coinsurance
OUTPATIENT RADIOLOGY	Deductible	Deductible then 50% Coinsurance	Deductible then 10% Coinsurance
PRESCRIPTION DRUGS			
Preferred Generic	\$15	\$15	Deductible then 10% Coinsurance
Preferred Brand	\$70	\$70	Deductible then 10% Coinsurance
Non-Preferred	\$110	\$110	Deductible then 10% Coinsurance
Preferred Specialty	Up to \$110	Up to \$110	Deductible then 10% Coinsurance
Employee Only	6	6	6
Employee + Spouse	0	0	0
Employee + Child(ren)	0	0	0
Family	0	0	0
RATES			
Employee Only	\$1,134.15	\$982.00	\$982.00
Employee + Spouse	\$2,858.06	\$2,474.64	\$2,474.64
Employee + Child(ren)	\$2,188.91	\$1,895.26	\$1,895.26
Family	\$3,243.67	\$2,808.52	\$2,808.52
MONTHLY	\$6,804.90	\$5,892.00	\$5,892.00
ANNUAL PREMIUM	\$81,658.80	\$70,704.00	\$70,704.00
% CHANGE	20.43%	4.28%	4.28%

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DENTAL BENEFITS	Principal 100/80/50/50 \$1,000 Current	Principal 100/80/50/50 \$1,000 Renewal
NETWORK	Principal Dental PPO	Principal Dental PPO
COINSURANCE		
Preventive	100%	100%
Basic	80%	80%
Major	50%	50%
Orthodontia	50%	50%
DEDUCTIBLE		
Individual	\$50	\$50
Family	\$150	\$150
ANNUAL PLAN MAXIMUM		
Preventive, Basic & Major	\$1,000	\$1,000
Orthodontia	\$1,000	\$1,000
COVERED SERVICES		
Endodontics	Major Service	Major Service
Periodontics	Basic Service	Basic Service
Composite Fillings	Basic Service for Posterior Teeth	Basic Service for Posterior Teeth
Oral Surgery	Basic for Simple; Major for Complex	Basic for Simple; Major for Complex
Employee Only	1	1
Employee + Spouse	1	1
Employee + Child(ren)	0	0
Family	0	0
RATES		
Employee Only	\$39.08	\$40.25
Employee + Spouse	\$80.55	\$82.96
Employee + Child(ren)	\$111.22	\$114.55
Family	\$161.31	\$166.15
TOTAL MONTHLY PREMIUM	\$119.63	\$123.21
TOTAL ANNUAL PREMIUM	\$1,435.56	\$1,478.52
% CHANGE		2.99%

This spreadsheet is for illustrative purposes only and does not include all contract provisions. Refer to the carrier summary for detailed information and out of network benefits.

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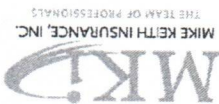
VISION BENEFITS	Principal Current	Principal Renewal
NETWORK	VSP Choice Network	VSP Choice Network
COPAY		
Examination	\$10	\$10
LENSES		
Single Vision / Bifocal / Trifocal	\$25	\$25
FRAME ALLOWANCE	\$150 Allowance	\$150 Allowance
CONTACT LENSES		
Medically Necessary	\$25 Copay	\$25 Copay
Elective	\$150 Allowance	\$150 Allowance
Fitting & Evaluation	Up to \$60 Copay	Up to \$60 Copay
FREQUENCY		
Exam	Every 12 Months	Every 12 Months
Lenses	Every 12 Months	Every 12 Months
Frames	Every 24 Months	Every 24 Months
Employee Only	4	4
Employee + Spouse	1	1
Employee + Child(ren)	0	0
Family	1	1
RATES		
Employee Only	\$9.23	\$9.23
Employee + Spouse	\$19.20	\$19.20
Employee + Child(ren)	\$21.88	\$21.88
Family	\$34.39	\$34.39
TOTAL MONTHLY PREMIUM	\$90.51	\$90.51
TOTAL ANNUAL PREMIUM	\$1,086.12	\$1,086.12
% CHANGE		0.00%

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LIFE AND AD&D BENEFITS	Principal Current	Principal Renewal
BENEFIT		
Employee	\$25,000	\$25,000
REDUCTION OF BENEFITS		
Age 65-69	35%	35%
Age 70+	50%	50%
RATE PER \$1000		
Life	\$0.527	\$0.527
AD&D	\$0.029	\$0.029
TOTAL VOLUME	\$175,000	\$175,000
NUMBER OF LIVES	7	7
TOTAL MONTHLY PREMIUM		
	\$97.30	\$97.30
TOTAL ANNUAL PREMIUM		
	\$1,167.60	\$1,167.60
% CHANGE		
		0.00%

Disclaimer / Disclosures



This proposal is intended for illustrative purposes only and should not be considered all inclusive of policy provisions and limitations. For additional details, see the carrier proposal and plan summary. This illustration is based on census data provided by the group. Actual costs are dependent upon final enrollment and member elections for the requested effective date. Recommendations are based on several criteria: Carrier Network, Cost, Benefit Funding Capabilities, Services, Etc., which best fit each client's needs. Mike Keith Insurance receives standard commissions from carriers which may include additional administrative fees and bonuses. Do not terminate existing coverage until replacement coverage has been confirmed in writing by the insurance carrier.

The Affordable Care Act - Summary of Changes to Medical Plans:

- 1) Unlimited Lifetime Benefit Maximum
- 2) Preventive Care Covered 100% In-Network
- 3) Dependent Children are eligible for coverage up to age 26
- 4) Waiting Period: Groups may not have a waiting period that exceeds 90 days
- 5) 2014/ACA Plans - Guarantee Issue
- 6) Out of Pocket Maximum - Limitations and Rules:
 - Beginning January 1, 2026, the out of pocket maximum must not exceed \$10,150 for individuals and \$20,300 for families for plans other than HDHPs with HSAs. The out of pocket maximum must not exceed \$8,500 for individuals and \$17,000 for families for plans that are HDHPs with HSAs. The rule requires that all member cost sharing (including deductibles, coinsurance, and copays) apply to these limits.
- Compliance with the rules can be accomplished one of two ways:
 - I. Integrated medical and pharmacy out of pocket maximum
 - II. Separate medical and pharmacy out of pocket maximums; when combined do not exceed the 2026 limits.
- 7) Essential Health Benefits: Beginning Jan. 1, 2014, the following categories will be included in Ambulatory Patient Services, Emergency Services, Hospitalization, Maternity and Newborn Care, Mental Health and Substance Abuse Services, Prescription Drugs, Rehabilitative and Habilitative Services and Devices, Laboratory Services, Preventive and Wellness Services and Chronic Disease Management; and Pediatric Dental and Pediatric Vision.