Teach Las Vegas

TEACH Las VegasGoverning Board Meeting

Amended on September 10, 2021 at 10:58 AM PDT

Date and Time
Tuesday September 14, 2021 at 6:00 PM PDT

Location
Beth Bulgeron is inviting you to a scheduled Zoom meeting.

Topic: TEACH Las Vegas Regular Board Meeting
Time: Sep 14, 2021 06:00 PM Pacific Time (US and Canada)

Join Zoom Meeting
https://teachpublicschools-org.zoom.us/j/84711588503?pwd=RmFUUDVOcWxYVHRvUlIlOElZVFdndz09

Meeting ID: 847 1158 8503
Passcode: 051179
One tap mobile
+16699006833,,84711588503#,,,,*051179# US (San Jose)
+13462487799,,84711588503#,,,,*051179# US (Houston)

Dial by your location
+1 669 900 6833 US (San Jose)
+1 346 248 7799 US (Houston)
+1 253 215 8782 US (Tacoma)
+1 312 626 6799 US (Chicago)
+1 929 205 6099 US (New York)
+1 301 715 8592 US (Washington DC)
Meeting ID: 847 1158 8503
Passcode: 051179
Find your local number: https://teachpublicschools-org.zoom.us/u/kRIHjkiZ6

This Board Meeting Agenda has been posted on the school's Board on Track page, which is linked from the TEACH Las Vegas webpage, and the official website of the state, https://notice.nv.gov. The agenda is also posted in the school's main office at 4660 N Rancho Drive, Las Vegas, NV 89130.

Agenda

	Purpose	Presenter	Time
I. Opening Items			**6:00 PM**
A. Call the Meeting to Order		Trishawn Allison	
B. Record Attendance		Beth Bulgeron	1 m
C. Public Comment		Trishawn Allison	10 m

Public Comment will be taken during this agenda item regarding any item appearing on the agenda. No action may be taken on a matter discussed under this item until the matter is included on an agenda as an item on which action may be taken. See NRS 241.020. A time limit of three (3) minutes, subject to the discretion of the Chair, will be imposed on public comments. The TEACH LV Chair may allow additional public comment at her discretion. Public Comment #2 will provide an opportunity for public comment on any matter not on the agenda.

II. CONSENT ITEMS			**6:11 PM**

Consent Items- Items under Consent Items will be voted on in one motion, unless a member of the Board request that an item be removed and voted on separately, in which case the Board Chair will determine when it will be balled and considered for action. Due to the set-up of Board On Track, approval of any board meeting minutes will be done throughout consent and listed as items B-Z (as needed) under Consent Items.

A. Approval of Board Agenda and Minutes of the August 10, 2021 Board Meeting	Vote	Trishawn Allison	3 m
III. ITEMS SCHEDULED FOR INFORMATION & POTENTIAL ACTION			**6:14 PM**
A. TEACH Las Vegas Fiscal Report	FYI	Theresa Thompson	5 m
B. Code of Ethics Policy	Vote	Beth Bulgeron	5 m
C. Board Policies Procedures	Vote	Beth Bulgeron	5 m

This policy provides procedures for introducing new policies and keeping the existing policies updated. This document, along with the Board's Bylaws, provides guidance for Board procedures as required by the Nevada Charter School Authority.

D. Update: New Board Member Recruitment	Discuss	Maria Pimienta	10 m
E. Executive Director's Report	FYI	Andrea Moore	10 m
F. Health Insurance Benefits Package for Teach Las Vegas Employees	Vote	Matthew Brown	5 m
IV. Closing Items			**6:54 PM**
A. Upcoming Meeting Date	FYI		5 m

The next regular Board Meeting is scheduled for October 12, 2021 at 6 pm.

B. Public Comment			5 m

	Purpose	Presenter	Time
C. Board Member Comments			5 m
D. Adjourn Meeting	Vote		

Cover Sheet

Approval of Board Agenda and Minutes of the August 10, 2021 Board Meeting

Section: II. CONSENT ITEMS
Item: A. Approval of Board Agenda and Minutes of the August 10, 2021 Board Meeting
Purpose: Vote
Submitted by:
Related Material: 2021_08_10_board_meeting_minutes (1).pdf

Teach Las Vegas

Minutes

TEACH Las Vegas Governing Board Meeting

Regular Meeting

Date and Time
Tuesday August 10, 2021 at 6:00 PM

Location
Beth Bulgeron is inviting you to a scheduled Zoom meeting.

Topic: TEACH Las Vegas Regular Board Meeting
Time: Aug 10, 2021 06:00 PM Pacific Time (US and Canada)

Join Zoom Meeting
https://teachpublicschools-org.zoom.us/j/82845711338?pwd=MjN0N2ZCV21vVzY3TFZ2WXVTYmxFQT09

Meeting ID: 828 4571 1338
Passcode: 919108
One tap mobile
+16699006833,,82845711338#,,,,*919108# US (San Jose)
+12532158782,,82845711338#,,,,*919108# US (Tacoma)

Dial by your location
- +1 669 900 6833 US (San Jose)
- +1 253 215 8782 US (Tacoma)
- +1 346 248 7799 US (Houston)
- +1 312 626 6799 US (Chicago)
- +1 929 205 6099 US (New York)
- +1 301 715 8592 US (Washington DC)

Meeting ID: 828 4571 1338
Passcode: 919108
Find your local number: https://teachpublicschools-org.zoom.us/u/kdEk2zvcWs

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state, https://notice.nv.gov. The agenda is also posted in the school's main office at 4660 N Rancho Drive, Las Vegas, NV 89130.

Directors Present
C. Igeleke (remote), D. Horn (remote), N. Sarisahin (remote), T. Allison (remote)

Directors Absent
J. Sinclair

Ex Officio Members Present
A. Moore (remote)

Non Voting Members Present
A. Moore (remote)

Guests Present
B. Bulgeron (remote), E. Robles (remote), M. Brown (remote), R. Carranza (remote), T. Thompson (remote)

I. Opening Items

A. Call the Meeting to Order
T. Allison called a meeting of the board of directors of Teach Las Vegas to order on Tuesday Aug 10, 2021 at 6:01 PM.

B. Record Attendance

C. Public Comment
No Public Comment

II. CONSENT ITEMS

A. Approval of Board Agenda and Minutes of the July 13, 2021 Board Meeting
T. Allison made a motion to Approve the agenda and approve the minutes from the previous board meeting.
N. Sarisahin seconded the motion.
The board **VOTED** to approve the motion.

Roll Call	
N. Sarisahin	Aye
D. Horn	Absent
J. Sinclair	Absent
C. Igeleke	Aye
T. Allison	Aye

III. ITEMS SCHEDULED FOR INFORMATION & POTENTIAL ACTION

A. TEACH Las Vegas Fiscal Report
Theresa Thompson from Charter Impact reviewed the financial report and provided an overall summary and recap of last month. Prior to Theresa's

presentation Matt gave brief updates on current financials and explained a more robust report will be provided once the June financials are completely closed out.

B. Revised Enrollment Policy

N. Sarisahin made a motion to Approve the Enrollment Policy.
T. Allison seconded the motion.
Beth Bulgeron gave a presentation on the revised enrollment policy and explained how the changes make the policy compliant with Nevada law and competitive with other schools for recruitment. There was a detailed discussion by the board regarding the pros and cons of the timing of the open enrollment window, how the public would interpret the language in the policy and the public messaging and recruitment that needs to happen in order to make recruitment and enrollment a success with this new policy. The board **VOTED** to approve the motion.

Roll Call	
T. Allison	Aye
D. Horn	Aye
J. Sinclair	Absent
C. Igeleke	Aye
N. Sarisahin	Aye

C. Executive Director's Report

ED Andrea Moore gave an extensive account of opening week at the school, updated enrollment numbers, the relationship with the school sharing the site and overall successes and challenges of the first week of a new school. She recapped the completion of the pre-opening assurances and the July site visit by the Nevada Charter School Authority. She also described the grade level combos and enrollment at each level. The Board discussed adding TK and congratulated Moore on her success in increasing enrollment and opening.

IV. Closing Items

A. Upcoming Meeting Date

The next scheduled Regular Board Meeting is September 14, 2021 at 6 pm.

B. Public Comment

There was no public comment.

C. Board Member Comments

Board member comments included a brief discussion on the status and strategies for recruiting new board members and a correction that needed to be made in the Employee Handbook that was approved at a previous meeting.

D. Adjourn Meeting

There being no further business to be transacted, and upon motion duly made, seconded and approved, the meeting was adjourned at 7:09 PM.

Respectfully Submitted,
T. Allison

Cover Sheet

Code of Ethics Policy

Section: III. ITEMS SCHEDULED FOR INFORMATION & POTENTIAL ACTION
Item: B. Code of Ethics Policy
Purpose: Vote
Submitted by:
Related Material: TEACH LV Code of Ethics draft copy.pdf

Board Governance

CODE OF ETHICS FOR BOARD MEMBERS

As a member of the Board, I shall promote the best interests of TEACH Las Vegas as a whole and, to that end, shall adhere to the following ethical standards:

Equity in Attitude

- I will be fair, just, and impartial in all my decisions and actions.
- I will accord others the respect I wish for myself.
- I will encourage expressions of different opinions and listen with an open mind to others' ideas.
- I will recognize that the authority of the board rests only with the board as a whole and not with individual members and act accordingly.

Trustworthiness In Stewardship

- I will be accountable to the public by representing School policies, programs, priorities, and progress accurately.
- I will be responsive to the community by seeking its involvement in School affairs and by communicating its priorities and concerns.
- I will work to ensure prudent and accountable use of School resources.
- I will make no personal promise or take private action that may compromise my performance or my responsibilities.

Honor In Conduct

- I will tell the truth.
- I will share my views while working for consensus.
- I will respect the majority decision as the decision of the Board.
- I will base my decisions on fact rather than supposition, opinion, or public favor.

Integrity Of Character

- I will refuse to surrender judgment to any individual or group at the expense of the School as a whole.
- I will consistently uphold all applicable laws, rules, policies, and governance procedures.
- I will not disclose information that is confidential by law or that will needlessly harm the School if disclosed.
- I will announce potential conflicts of interest before board action is taken.

Commitment To Service

- I will focus my attention on fulfilling the Board's responsibilities of goal setting, policymaking, and evaluation.
- I will diligently prepare for and attend Board meetings.
- I will avoid personal involvement in activities the Board has delegated to the Director.
- I will seek continuing education that will enhance my ability to fulfill my duties effectively.

Student-Centered Focus

- I will be continuously guided by what is best for all students of the School.

Adopted:

Amended:

Cover Sheet

Board Policies Procedures

Section: III. ITEMS SCHEDULED FOR INFORMATION & POTENTIAL ACTION
Item: C. Board Policies Procedures
Purpose: Vote
Submitted by:
Related Material: LV Procedure for Policy Adoption.pdf

Procedure for Policy Adoption

This Procedure for Policy Adoption is consistent with the bylaws and articles of incorporation of Teach Las Vegas.

Policies create guidance and procedures for the organization and employees to follow to achieve the Teach Las Vegas mission and vision. An effective policy provides a roadmap for day-to-day operations and ensures compliance with laws and regulations, gives guidance for decision-making, and streamlines internal processes.

The successful operation of Teach Las Vegas requires that the actions of the Board and administrative staff be known and understood by students, parents, employees and members of the community. These groups as well as individuals should also have an opportunity to affect Teach Las Vegas action.

The process for adoption and publication in Teach Las Vegas includes the following elements:

I. Raise a Policy Issue

Any person within the school community, including teachers, administrative staff, other staff members, students, parents, and interested community members, may raise a potential policy issue. At the school level, the individual that raises the policy issue shall communicate that policy issue to the Director in writing via email. The Director shall communicate the policy issue to the Director of Governance and Compliance within one week of receiving the policy issue. The Director of Governance and Compliance will evaluate the issue, confer with the Chief Operating Officer and present the issue with a recommendation to the Board. All notifications of policy issues will be brought before the Board, whether or not staff recommends a policy be created.

The Board may raise a policy issue itself through email or in an open meeting.

II. Policy Drafting

Once the Board has heard the policy issue, the Board shall consider the issues relating to the policy and undertake to amend the draft policy, or delegate drafting or revisions to an appropriate person or group of persons.

III. Adoption, Revision and Repeal of Policies

The adoption, revision or repeal of a policy shall be made in an open and public manner at a regular or special charter school board meeting. An opportunity for interested parties to be heard before adoption, revision or repeal of policy shall be made.

Publication and availability of all policies currently in effect within the school shall be made to any interested person during the regular business hours of the school and shall be made easily accessible on the school's website.

VI. Review and Revision of Existing Policies

No later than June 30 of any school year, the Board shall complete a review of all the existing policies of the school. In reviewing the existing policies of the school, the Board shall determine whether a policy requires revision.

Adopted:

Amended:

Cover Sheet

Health Insurance Benefits Package for Teach Las Vegas Employees

Section:	III. ITEMS SCHEDULED FOR INFORMATION & POTENTIAL ACTION
Item:	F. Health Insurance Benefits Package for Teach Las Vegas Employees
Purpose:	Vote
Submitted by:	
Related Material:	TEACH DISTIINCTIVE INS QUOTE (1).pdf Teach - NV PPO plans.pdf TEACH Inc LV - All State (1).pdf Apex MEC Warner CA Aug 2021 - TEACH LV (2).pdf

2021 - CA Plan Options

WARNER Pacific

APEX MANAGEMENT GROUP

beazley

BALANCING HEALTH CARE COSTS

APEX
Minimum Essential Coverage (MEC)

COVERS:

Telehealth services
at 100% of cost

Certain preventive health services
at 100% of cost

Physician visits and diagnostic testing
with copay

Prescription drug benefits
with copay or coinsurance

When delivered by an in-network provider.

BEAZLEY
Group Limited Indemnity (GLI)

PAYS A FIXED BENEFIT AMOUNT FOR A SET NUMBER OF DAYS PER YEAR FOR:

Hospitalization

Surgeries

Emergency Room visits

Group Limited Indemnity (GLI) is not major medical insurance or PPACA compliant.

COMPLIANCE • PREVENTION • BENEFITS

The Apex MEC is PPACA compliant, ideal for $8 - $20 per hour full or part-time employees and seasonal staff, nationwide.

4-Year Rate Cap - MEC

Not to exceed 3% increase per year.

Group Limited Indemnity Insurance is underwritten by Beazley Insurance Company, Inc., 30 Batterson Park Road, Farmington, Connecticut, 06032.

PH_3_21

Valued Partners Nationwide

PHCS

Network
- 900,000+ healthcare providers
- 68 million consumers
- 40 million claims

multiplan.com

CITIZENS Rx

Pharmacy Benefit Manager
- Call Center available 24/7/365
- Contracted with 67,000 pharmacies nationwide

citizensrx.com

TELADOC

Telehealth
- 20,000,000 members nationwide
- 92% of issues resolved after first visit
- 360 languages
- 24/7/365 access to a national network of U.S. board-certified physicians and pediatricians

teladoc.com

RCI

TPA
- Leading Third Party Administrator
- Specializing in PPACA compliant, value-added healthcare solutions
- Delivering exemplary services to clients and broker partners
- Managing health care costs effectively

regionalcare.com

CF EST. 1822

Reinsurance
- Rated A (Excellent) by A.M. Best
- Applicable in states that allow reinsurance on MEC plans

cfins.com

beazley

Specialist Insurer
- Three decades of experience
- Providing clients the highest standards of underwriting and claims service worldwide
- All our insurance businesses are rated A (Excellent) by A.M. Best

beazley.com

Plan Highlights

Apex MEC Benefits

All Apex MEC plans exceed the requirements employers / employees are currently required to meet under Penalty A of the PPACA.

- TELADOC 24/7 (multilingual)
- Pharmacy Benefits (Citizens Rx)
- Preventive Care Visit
- Primary Care Visits (3 per plan year)
- Specialists Visits (3 per plan year)
- Urgent Care Visits (3 per plan year)
- MRI & CT Scan Benefits (max 1 CT or MRI per plan year)
- X-ray and Lab Benefits (5 per plan year)

Additional Information:
- Guaranteed issue product
- COBRA services are included in premium
- 1094 information is provided at no additional charge
- If member exceeds 3 primary care, 3 specialists and/or 3 urgent care visits, member will receive PHCS network discount
- ITIN & H-2A qualify for benefit membership

Beazley GLI Benefits

Group Limited Indemnity insurance pays fixed benefits when an insured incurs charges for services covered by the plan. Benefits for each covered service are paid at a specified amount per day to a maximum number of days per year.

No medical questions are required to qualify for coverage. Employees may opt for coverage for spouses and child(ren). NOTE: Group Limited Indemnity is not major medical insurance.

- Guaranteed issue
- 1-year rate guarantee
- See Beazley proposal for product details and benefit definitions
- Illustrated GLI plan designs available to groups sitused in CA.

Group Limited Indemnity insurance are underwritten by Beazley Insurance Company, Inc., 30 Batterson Park Road, Farmington, Connecticut, 06032. Beazley is rated A by A.M. Best. Beazley is licensed in all 50 states and the District of Columbia. CA License #2868-8. The Group Limited Indemnity policy is offered under Policy Form Series AHGLIMM0001. Coverage is not available in all states. Benefits may vary by state. Premium will vary based on the plan chosen. A waiting period for late entrants may apply. This policy is renewable at the option of Beazley. Refer to the Master Policy and Certificate for all terms, conditions, exclusions and limitations. Beazley uses the services of a third party administrator.

Apex MEC* & Beazley Group Limited Indemnity (GLI)[1] Plans

	7 EE minimum Employer must fund 50% of the premium	7 EE minimum	7 EE minimum
PREVENTIVE BENEFITS* MEC benefits cover 100% of the cost of certain preventive health services, when delivered by a doctor or provider in your plan's network. Services include but are not limited to: • For Adults: Screenings for blood pressure, cholesterol and colon cancer, plus immunizations. • For Women: Screenings for breast cancer, cervical cancer and osteoporosis, plus pregnancy services. • For Children: Immunizations, plus screenings for child development, vision and hearing. For a full list of covered preventive health services, visit www.HealthCare.gov/center/regulations/prevention.html	**MEC BASIC WITH BEAZLEY GLI[1]**	**MEC WITH BEAZLEY GLI[1]**	**MEC PLUS ADVANTAGE WITH BEAZLEY GLI[1]**
	FREE 1 preventive visit per plan year	**FREE** 1 preventive visit per plan year	**FREE** 1 preventive visit per plan year
TELADOC 24/7 (Multilingual)[2]	**FREE (unlimited)**	**FREE (unlimited)**	**FREE (unlimited)**
PPO NETWORK SERVICES[2]			
Primary Care Physician Visits	**See Beazley GLI Benefits Below**	**$20 Copay** max 2 visits per plan year	**$20 Copay** max 3 visits per plan year
Specialist Office Visits		**Not Covered**	**$50 Copay** max 3 visits per plan year
Urgent Care		**$50 Copay** max 2 visits per plan year	**$50 Copay** max 3 visits per plan year
Diagnostic X-ray and Lab		**See Beazley GLI Benefits Below**	**$50 Copay** in offices, max 5 services per plan year
CT Scan/MRI (outpatient only)			**$200 Copay** max 1 CT Scan or 1 MRI per plan year
PRESCRIPTION BENEFITS[2]			
Tier 1 - Low Cost	**Discount Card** Up to 75% Discount on FDA Approved Medications	**$1 Copay**	**$1 Copay**
Tier 2 - Generics		**10% Coinsurance**	**10% Coinsurance**
Tier 3 - Preferred		**20% Coinsurance**	**20% Coinsurance**
Tier 4 - Non-Preferred		**40% Coinsurance**	**40% Coinsurance**
Tier 5 - Generic & Preferred Specialty		**10% Coinsurance** Plan pays 90%	**10% Coinsurance** Plan pays 90%
Tier 6 - Non-Preferred		**20% Coinsurance** Plan pays 80%	**20% Coinsurance** Plan pays 80%
LIMITED INDEMNITY BENEFITS Hospital Indemnity Benefits	**GLI Underwritten by Beazley Insurance Company, Inc.**	**GLI Underwritten by Beazley Insurance Company, Inc.**	**GLI Underwritten by Beazley Insurance Company, Inc.**
Hospital Confinement For treatment in a hospital, due to sickness or injury for 23 or more continuous hours (i.e., not less than a day) Note: Maternity benefit is payable as any other illness for both mother and child	**$400 per day** 30 days per plan year	**$500 per day** 10 days per plan year	**$1,000 per day** 30 days per plan year
Hospital Intensive Care Unit For intensive and comprehensive care, when confined in an area equipped with lifesaving equipment (ICU)	**$1,000 per day** 10 days per plan year	**$1,000 per day** 10 days per plan year	**$1,250 per day** 10 days per plan year
Hospital Admission Lump sum benefit for a hospital admission, due to sickness or injury Note: Admission benefit for birth of a healthy child covers mother only. Benefit is payable for newborn if admitted to ICU	**None**	**None**	**$2,000 per day** 1 day per plan year
Surgery/Anesthesia Benefits			
Inpatient Surgery For inpatient surgery in hospital due to sickness or injury	**$750 per day** 1 day per plan year	**$500 per day** 1 day per plan year	**$1,000 per day** 2 days per plan year
Outpatient Surgery For outpatient surgery in hospital or freestanding surgery center, due to sickness or injury	**$150 per day** 1 day per plan year	**$150 per day** 2 days per plan year	**$500 per day** 1 day per plan year
Anesthesia For general anesthesia administered by an anesthesiologist or Certified Registered Nurse Anesthetist (payable with inpatient and outpatient major surgeries only)	**$300 per day** 2 days per plan year	**$300 per day** 1 day per plan year	**$300 per day** 1 day per plan year
Emergency Room Benefits			
Emergency Room for Sickness For treatment in an ER due to sickness	**$150 per day** 1 day per plan year	**$50 per day** 2 days per plan year	**$50 per day** 2 days per plan year
Emergency Room for Accidental Injury For treatment in an ER due to injury (treatment must occur within 72 hours of the accident)	**None**	**$150 per day** 2 days per plan year	**$150 per day** 2 days per plan year
Outpatient & Other Benefits			
Physician Office Visit/Urgent Care For services rendered by a physician at physician's office or urgent care facility	**$50 per day** 3 days per plan year	**See MEC Benefits Above**	**See MEC Plus Advantage Benefits Above**
Outpatient Diagnostic Lab For lab test, ordered by a physician	**$50 per day** 3 days per plan year	**$25 per day** 3 days per plan year	
Outpatient Diagnostic X-ray For X-ray, ordered by a physician	**$50 per day** 2 days per plan year	**$75 per day** 1 day per plan year	
Outpatient Major Diagnostic Testing For major diagnostic testing, ordered by a physician	**None**	**$250 per day** 1 day per plan year	
Skilled Nursing Care Facility For confinement in a Skilled Nursing Care Facility within 14 days of a hospital confinement of at least 3 days	**$150 per day** 10 days per plan year	**None**	**None**
TOTAL MONTHLY PREMIUMS [PAID BY EMPLOYEE]	**1-YEAR RATE CAP[3]**	**1-YEAR RATE CAP[3]**	**1-YEAR RATE CAP[3]**
Employee only	$52.00 + $ 37.75 = **$ 89.75**	$ 98.00 + $38.00 = **$136.00**	$133.75 + $ 63.69 = **$197.44**
Employee & Spouse only	$79.25 + $ 76.13 = **$155.38**	$181.24 + $74.00 = **$255.24**	$218.24 + $130.57 = **$348.81**
Employee & Children only	$79.25 + $ 66.90 = **$146.15**	$165.24 + $60.00 = **$225.24**	$202.24 + $114.53 = **$316.77**
Family	$79.25 + $107.28 = **$186.53**	$256.30 + $96.00 = **$352.30**	$293.30 + $190.26 = **$483.56**

* The Apex MEC plans are PPACA compliant; they are offered by Apex Management Group and administered by RCI. Beazley does not underwrite the MEC plans or the non-insurance benefits.

[1] Group Limited Indemnity is not major medical insurance. GLI is not PPACA compliant and does not satisfy any PPACA penalties.

[2] Non-insurance benefits are included with Apex MEC plans.

[3] Beazley premium is illustrated in pink and is offered to groups situsted in CA with a 1-year rate guarantee. Coverage is not available in all states. Benefits may vary by state. Minimum participation requirements apply.

GLI insurance is underwritten by Beazley Insurance Company, Inc., 30 Batterson Park Road, Farmington, Connecticut, 06032. Beazley is rated A by A.M. Best. Beazley is licensed in all 50 states and the District of Columbia.

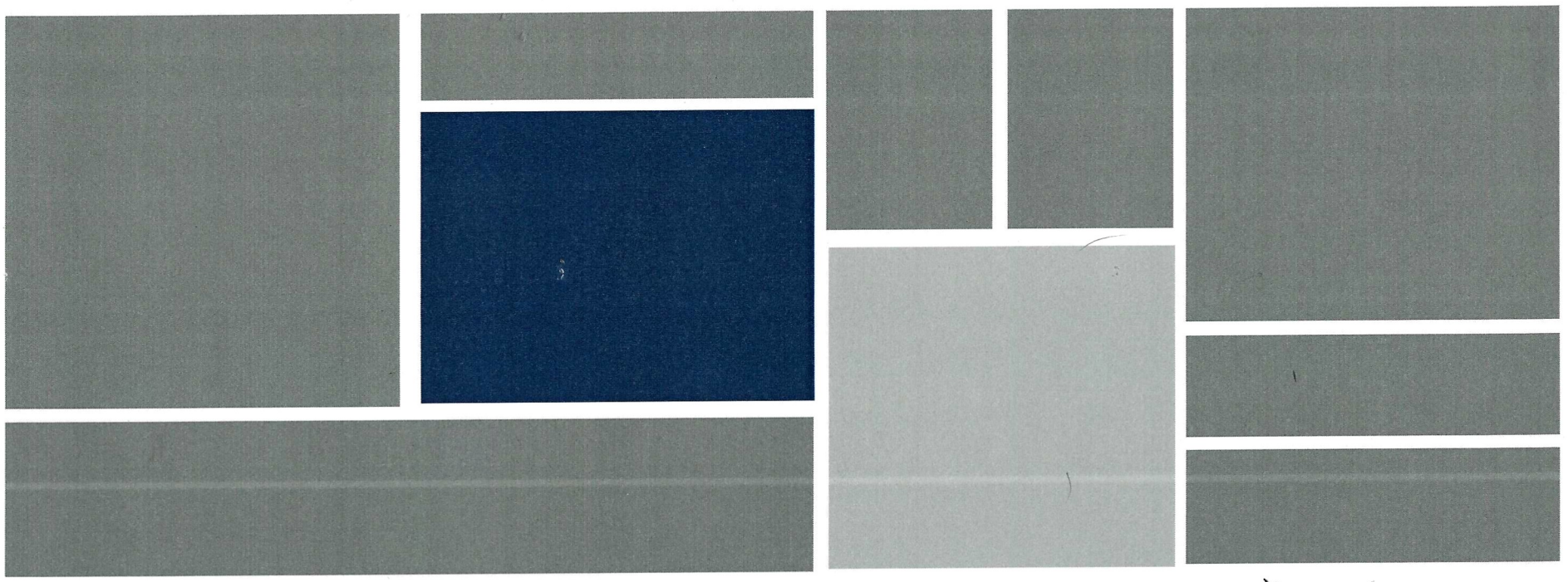
Apex MEC Plans

	4 EE minimum	4 EE minimum	4 EE minimum
PREVENTIVE BENEFITS MEC benefits cover 100% of the cost of certain preventive health services, when delivered by a doctor or provider in your plan's network.	**MEC BASIC**	**MEC**	**MEC PLUS ADVANTAGE**
	FREE 1 preventive visit per plan year	**FREE** 1 preventive visit per plan year	**FREE** 1 preventive visit per plan year
TELADOC **TELADOC 24/7 (Multilingual)**	**FREE (unlimited)**	**FREE (unlimited)**	**FREE (unlimited)**
PHCS **PPO NETWORK SERVICES**			
Primary Care Physician Visits	**Not Covered**	**$0 Copay** max 1 visit per plan year	**$20 Copay** max 3 visits per plan year
Specialist Office Visits			**$50 Copay** max 3 visits per plan year
Urgent Care			**$50 Copay** max 3 visits per plan year
Diagnostic X-ray and Lab			**$50 Copay** in offices, max 5 services per plan year
CT Scan/MRI (outpatient only)			**$200 Copay** max 1 CT Scan or 1 MRI per plan year
CITIZENS **PRESCRIPTION BENEFITS**			
Tier 1 - Low Cost	**Discount Card** Up to 75% Discount on FDA Approved Medications	**Discount Card** Up to 75% Discount on FDA Approved Medications	**$1 Copay**
Tier 2 - Generics			**10% Coinsurance**
Tier 3 - Preferred			**20% Coinsurance**
Tier 4 - Non-Preferred			**40% Coinsurance**
Tier 5 - Generic & Preferred Specialty			**10% Coinsurance** Plan pays 90%
Tier 6 - Non-Preferred			**20% Coinsurance** Plan pays 80%
TOTAL MONTHLY PREMIUMS	**4-YEAR RATE CAP**	**4-YEAR RATE CAP**	**4-YEAR RATE CAP**
Employee only	**$ 58.75**	**$ 70.00**	**$133.75**
Employee & Spouse only	**$ 86.00**	**$ 90.00**	**$218.24**
Employee & Children only	**$ 86.00**	**$ 90.00**	**$202.24**
Family	**$ 86.00**	**$ 90.00**	**$293.30**

ADDITIONAL INFORMATION

- This MEC (Minimum Essential Coverage) plan includes coverage for all preventive care services recommended by the U.S. Preventive Services Task Force (USPTF) and mandated by the Patient Protection and Affordable Care Act (PPACA), including but not limited to routine physical exams, associated imaging and laboratory services (such as mammograms and PSA tests), well-child exams, and immunizations. For complete details, exclusions and limitations on PPACA required coverage, visit www.healthcare.gov.
- Apex covers preventive services as required under the PPACA and are only covered at 100% when utilizing in-network providers.
- TELADOC provides 24/7/365 access to a national network of U.S. board-certified doctors and pediatricians through the convenience of phone or online video consultations. TELADOC also provides access to mental health benefits.
- TELADOC is available to every enrolled employee, their spouse or domestic partner, and their children up to the age of 26.
- All Apex plans comply with State Individual Mandate laws including California, District of Columbia, New Jersey, Rhode Island and Vermont. These plans do not meet the Minimum Creditable Coverage (MCC) standards in Massachusetts therefore they do not satisfy the Individual Mandate.
- The Patient Centered Outcomes Research Institute (PCORI) fees are the responsibility of the Employer.
- An Employer can choose up to 2 of the 5 plan designs per plan year.
- The Apex MEC product offerings are ***not*** Major Medical plans, they are limited benefit plans.

P R O P O S A L



P R E P A R E D F O R

20th - 15th October

Teach LV

distinctive INSURANCE
AN ALERA GROUP COMPANY

C O N T A C T

Distinctive Insurance
8375 W. Flamingo Rd. Ste 102
Las Vegas, NV 89147

Account Manager
Jessica Lepianka
jess@distinctive.net
Phone: (702) 990-6947
Fax: (702) 396-4832

Employee Benefits Consultant
Marc Fish
marc@distinctive.net
Phone: (702) 396-4844
Fax: (702) 396-4832

Health Plan of Nevada Association Health Plans

Medical Benefits	OPTION HMO Balance 30/5000 In Network	OPTION HMO Balance 10/3300 In Network	OPTION HMO Balance 20/1750 In Network	OPTION HMO Plus 30/5000-4A In Network
DEDUCTIBLE & OUT-OF-POCKET MAXIMUMS				
Individual Deductible	$5,000	$3,300	$1,750	$5,000
Family Deductible	$10,000	$6,600	$3,500	$10,000
Individual Out-of-Pocket Maximum	$8,150	$7,300	$7,000	$6,850
Family Out-of-Pocket Maximum	$16,300	$14,600	$14,000	$13,700
PHYSICIAN & DIAGNOSTIC SERVICES				
Primary Care Physician	$30	$10	$20	$30
Specialist	$60	$20	$40	$60
Telemedicine	$0	$0	$0	$0
Lab Services	$10	$10	$10	$10
X-ray Services	$20	$10	$10	$20
FACILITY FEES				
Urgent Care	$35	$35	$35	$35
Emergency Room	$1,000 after ded.	$1,000 after ded.	$1,000 after ded.	$1,000 after ded.
Inpatient Hospital	$2,000 after ded.	$2,000 after ded. per day, not to exceed $6,000 per admission	$1,000 after ded. per day, not to exceed $3,000 per admission	$2,000 after ded.
Surgery Center	$100	$100	$100	$100
Outpatient Hospital Surgery	$1,000 after ded.	$1,000 after ded.	$1,000 after ded.	$1,000 after ded.
PRESCRIPTION DRUGS				
Deductible	N/A	N/A	N/A	N/A
Tiers 1-4 Copays	$10 / $40 / $85 / $250	$10 / $40 / $85 / $250	$10 / $40 / $85 / $250	$15 / $40 / $60 / $150
Premium Summary				
Andrea Moore	$578.31	$621.08	$678.07	$701.03
Tricia Metzel	$817.18	$877.61	$958.14	$990.58
Gina Piet	$779.46	$837.10	$913.92	$944.86
Megan Davis	$364.59	$391.55	$427.48	$441.95
Tiffany Aab	$452.59	$486.06	$530.66	$548.63
O'Rane Forrester	$201.15	$216.02	$235.85	$243.83
Nicole Hubble	$729.18	$783.10	$854.96	$883.90
Samantha Terranova	$201.15	$216.02	$235.85	$243.83
Katie Strickland	$201.15	$216.02	$235.85	$243.83
Harmony Chavez	$238.87	$256.53	$280.07	$289.55
Estimated Monthly Total	$4,563.63	$4,901.09	$5,350.85	$5,531.99

↓ HMO option

no CVS

Health Plan of Nevada Association Health Plans

Medical Benefits	OPTION HMO Plus 20/2000-3D In Network	OPTION HMO Plus 30/500-3D In Network	OPTION HMO Plus 15 In Network	OPTION POS 15/1000/2500/30% HMO	OPTION POS 15/1000/2500/30% PPO	OPTION POS 15/1000/2500/30% Out of network
DEDUCTIBLE & OUT-OF-POCKET MAXIMUMS						
Individual Deductible	$2,000	$500	N/A	$1,000	$2,500	$5,000
Family Deductible	$4,000	$1,000	N/A	$2,000	$5,000	$10,000
Individual Out-of-Pocket Maximum	$6,850	$6,850	$6,000	$6,850	$6,850	$15,000
Family Out-of-Pocket Maximum	$13,700	$13,700	$12,000	$13,700	$13,700	$30,000
PHYSICIAN & DIAGNOSTIC SERVICES						
Primary Care Physician	$20	$30	$15	$15	$30	50% after ded.
Specialist	$40	$60	$30	$30	$60	50% after ded.
Telemedicine	$0	$0	$0	$0	Not Covered	Not Covered
Lab Services	$10	$10	$10	$10	$25	50% after ded.
X-ray Services	$20	$20	$25	$20	$50	50% after ded.
FACILITY FEES						
Urgent Care	$35	$35	$20	$40	$40	$40
Emergency Room	$1,000 after ded.	$1,000 after ded.	$200	$1,000 after ded.	$1,000 after ded.	$1,000 after ded.
Inpatient Hospital	$1,000 after ded. per day, not to exceed $3,000 per admission	$1,000 after ded. per day, not to exceed $3,000 per admission	$500	$1,000 after ded. per day, not to exceed $3,000 per admission	30% after ded.	50% after ded.
Surgery Center	$100	$100	$100	$100	30% after ded.	50% after ded.
Outpatient Hospital Surgery	$1,000 after ded.	$1,000 after ded.	$250	$500	30% after ded.	50% after ded.
PRESCRIPTION DRUGS						
Deductible	N/A	N/A	N/A	N/A		
Tiers 1-4 Copays	$15 / $40 / $60 / $150	$25 / $50 / $75 / $250	$15 / $40 / $60 / $150	$15 / $40 / $60 / $250		
Premium Summary						
Andrea Moore	$757.48	$776.51	$896.45	$997.92		
Tricia Metzel	$1,070.35	$1,097.24	$1,266.72	$1,410.11		
Gina Piet	$1,020.95	$1,046.60	$1,208.26	$1,345.02		
Megan Davis	$477.54	$489.54	$565.15	$629.13		
Tiffany Aab	$592.81	$607.70	$701.57	$780.98		
O'Rane Forrester	$263.47	$270.09	$311.81	$347.10		
Nicole Hubble	$955.08	$979.08	$1,130.30	$1,258.26		
Samantha Terranova	$263.47	$270.09	$311.81	$347.10		
Katie Strickland	$263.47	$270.09	$311.81	$347.10		
Harmony Chavez	$312.87	$320.73	$370.27	$412.19		
Estimated Monthly Total	$5,977.49	$6,127.67	$7,074.15	$7,874.91		

PPO ↓ option PO senci

Teach LV				HPN/SHL AHP			
				OPTION	OPTION	OPTION	OPTION
				ACA Compliant Group Plan 2021	ACA Compliant Group Plan 2021	ACA Compliant Group Plan 2021	ACA Compliant Group Plan 2021
Last Name	First Name	Age	Status	HMO Balance 30/5000	HMO Balance 10/3300	HMO Balance 20/1750	HMO Plus 30/5000-4A
Moore	Andrea	50	ECH	$326.87	$351.04	$383.25	$396.23
Moore	Benjamin	19	Dependent	$125.72	$135.02	$147.41	$152.40
Moore	Ryan	17	Dependent	$125.72	$135.02	$147.41	$152.40
Metzel	Tricia	43	FAM	$238.87	$256.53	$280.07	$289.55
Metzel	Joseph	49	Spouse	$326.87	$351.04	$383.25	$396.23
Metzel	Jeremy	18	Dependent	$125.72	$135.02	$147.41	$152.40
Metzel	Emma	16	Dependent	$125.72	$135.02	$147.41	$152.40
Piet	Gina	47	ECH	$326.87	$351.04	$383.25	$396.23
Piet	Blake	10	Dependent	$125.72	$135.02	$147.41	$152.40
Piet	Julia	18	Dependent	$125.72	$135.02	$147.41	$152.40
Piet	Katie	20	Dependent	$201.15	$216.02	$235.85	$243.83
Davis	Megan	38	ECH	$238.87	$256.53	$280.07	$289.55
Davis	Preslie	10	Dependent	$125.72	$135.02	$147.41	$152.40
Aab	Tiffany	45	ECH	$326.87	$351.04	$383.25	$396.23
Aab	Zander	18	Dependent	$125.72	$135.02	$147.41	$152.40
Forrester	O'Rane	32	EE	$201.15	$216.02	$235.85	$243.83
Hubble	Nicole	42	FAM	$238.87	$256.53	$280.07	$289.55
Hubble	Jeremy	42	Spouse	$238.87	$256.53	$280.07	$289.55
Hubble	Tyler	18	Dependent	$125.72	$135.02	$147.41	$152.40
Hubble	Austin	16	Dependent	$125.72	$135.02	$147.41	$152.40
Terranova	Samantha	22	EE	$201.15	$216.02	$235.85	$243.83
Strickland	Katie	26	EE	$201.15	$216.02	$235.85	$243.83
Chavez	Harmony	36	EE	$238.87	$256.53	$280.07	$289.55
Monthly Total				$4,563.63	$4,901.09	$5,350.85	$5,531.99

HMO costs per employee

Teach LV				HPN/SHL AHP			
				OPTION	OPTION	OPTION	OPTION
				ACA Compliant Group Plan 2021	ACA Compliant Group Plan 2021	ACA Compliant Group Plan 2021	ACA Compliant Group Plan 2021
Last Name	First Name	Age	Status	HMO Plus 20/2000-3D	HMO Plus 30/500-3D	HMO Plus 15	POS 15/1000/2500/30%
Moore	Andrea	50	ECH	$428.14	$438.89	$506.69	$564.04
Moore	Benjamin	19	Dependent	$164.67	$168.81	$194.88	$216.94
Moore	Ryan	17	Dependent	$164.67	$168.81	$194.88	$216.94
Metzel	Tricia	43	FAM	$312.87	$320.73	$370.27	$412.19
Metzel	Joseph	49	Spouse	$428.14	$438.89	$506.69	$564.04
Metzel	Jeremy	18	Dependent	$164.67	$168.81	$194.88	$216.94
Metzel	Emma	16	Dependent	$164.67	$168.81	$194.88	$216.94
Piet	Gina	47	ECH	$428.14	$438.89	$506.69	$564.04
Piet	Blake	10	Dependent	$164.67	$168.81	$194.88	$216.94
Piet	Julia	18	Dependent	$164.67	$168.81	$194.88	$216.94
Piet	Katie	20	Dependent	$263.47	$270.09	$311.81	$347.10
Davis	Megan	38	ECH	$312.87	$320.73	$370.27	$412.19
Davis	Preslie	10	Dependent	$164.67	$168.81	$194.88	$216.94
Aab	Tiffany	45	ECH	$428.14	$438.89	$506.69	$564.04
Aab	Zander	18	Dependent	$164.67	$168.81	$194.88	$216.94
Forrester	O'Rane	32	EE	$263.47	$270.09	$311.81	$347.10
Hubble	Nicole	42	FAM	$312.87	$320.73	$370.27	$412.19
Hubble	Jeremy	42	Spouse	$312.87	$320.73	$370.27	$412.19
Hubble	Tyler	18	Dependent	$164.67	$168.81	$194.88	$216.94
Hubble	Austin	16	Dependent	$164.67	$168.81	$194.88	$216.94
Terranova	Samantha	22	EE	$263.47	$270.09	$311.81	$347.10
Strickland	Katie	26	EE	$263.47	$270.09	$311.81	$347.10
Chavez	Harmony	36	EE	$312.87	$320.73	$370.27	$412.19
Monthly Total				$5,977.49	$6,127.67	$7,074.15	$7,874.91

PPO
cost per employee

DENTAL PLAN ANALYSIS

	OPTION Renaissance Triple Advantage			OPTION Guardian 100/80/50 $1,500 Max		OPTION Principal 100/80/50 $1,500 Max	
	Elite Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
DEDUCTIBLE & MAXIMUMS							
Individual Deductible	$50	$50	$50	$50	$50	$50	$50
Family Deductible	$150	$150	$150	$150	$150	$150	$150
Annual Benefit Maximum	$1,500	Combined	Combined	$1,500	Combined	$1,500	Combined
Orthodontia Lifetime Maximum	N/A	N/A	N/A	N/A	N/A	N/A	N/A
COINSURANCE							
Type A - Preventive	100%	100%	100%	100%	80%	100%	80%
Type B - Basic	100%	80%	80%	80%	80%	80%	60%
Type C - Major	80%	50%	50%	50%	50%	50%	40%
BENEFIT DETAILS							
Root Canal	Basic			Basic		Basic	
Periodontal Surgery	Basic			Basic		Basic	
Complex Oral Surgery	Basic			Basic		Basic	
Implants	Major			Major		Not Covered	
OTHER FEATURES							
Waiting Periods	None			None		None	
Participation Requirement	50%			75%		50%	

PREMIUM SUMMARY

Tier	Counts	Monthly Rate	Monthly Rate	Monthly Rate
Employee Only	10	$36.52	$41.89	$34.07
Employee + Spouse	0	$73.05	$85.03	$60.06
Employee + Child(ren)	0	$85.84	$95.64	$85.29
Employee + Family	0	$137.19	$147.06	$117.43
Estimated Monthly Premium		**$365.20**	**$418.90**	**$340.70**
Estimated Annual Premium		**$4,382.40**	**$5,026.80**	**$4,088.40**

26.40

Shelly
Valed
product
2nd change
Root canal
major not basic

VISION PLAN ANALYSIS

	OPTION Renaissance $10/$25 12/12/24		OPTION Guardian $10/$25 12/12/24		OPTION Principal $10/$25 12/12/24	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
COPAYS						
Exams	$10	$45 allowance	$10	$39 allowance	$10	$45 allowance
Lenses for Glasses	$25	Allowance varies	$25	Allowance varies	$25	Allowance varies
Frames	$130 allowance	$70 allowance	$130 allowance	$46 allowance	**$150 allowance**	$70 allowance
Elective Contact Lenses	$130 allowance	$105 allowance	$130 allowance	$100 allowance	**$150 allowance**	$105 allowance
FREQUENCIES						
Exams	Every 12 months		Every 12 months		Every 12 months	
Lenses	Every 12 months		Every 12 months		Every 12 months	
Frames	Every 24 months		Every 24 months		Every 24 months	
OTHER FEATURES						
Participation Requirement	50%		75%		50%	
Network	VSP		VSP		VSP	

PREMIUM SUMMARY

Tier	Counts	Monthly Rate	Monthly Rate	Monthly Rate
Employee Only	10	$7.42	$7.97	$9.53
Employee + Spouse	0	$14.85	$13.42	$16.15
Employee + Child(ren)	0	$15.88	$13.68	$19.83
Employee + Family	0	$25.40	$21.65	$28.50
Estimated Monthly Premium		**$74.20**	**$79.70**	**$95.30**
Estimated Annual Premium		**$890.40**	**$956.40**	**$1,143.60**

Allstate BENEFITS

Presented by Allstate Benefits

Self-Funded Medical Plan Proposal
September 10, 2021

Agent: Rob Stenzel
Phone: (310) 270-8744
Email:

Rep Name: Roger Bennett
Email: Roger.Bennett@NGIC.COM

Proposal For: **TEACH, Inc.**

This is not an insurance contract, nor does it guarantee coverage or effective date. Only the actual contract provisions will prevail. See the plan brochures for coverage and option details. This quote must be presented by a State-licensed agent and is subject to approval.

The Allstate Benefits Self-Funded Program provides tools for small to mid-sized businesses to establish a self-funded health benefit plan for their employees. The benefit plan is established by the employer and is not an insurance product. For employers in the Allstate Benefits Self-Funded Program, stop-loss insurance is underwritten by Integon National Insurance Company in CT, NY and VT; Integon Indemnity Corporation in FL; and National Health Insurance Company in all other states where offered.

Allstate BENEFITS

Group Name: TEACH, Inc.
Effective Date: 10/01/2021
SIC Code: 82100
Location Name: Location 1 Zip Code: 89130
Location Type: Main

Plan/Rate Summary

Please review this proposal. If you are ready to move forward, contact your Licensed Agent or Sales Representative to discuss the next steps.
Plans quoted in this proposal: 6

Plan Name	LocalPlus PPO 1	LocalPlus PPO 2	LocalPlus HSA
Plan Type	Traditional	Traditional	Traditional
Medical Plan Design	SELF-FUNDED PPO COPAY PLAN	SELF-FUNDED PPO COPAY PLAN	SELF-FUNDED HSA PPO PLAN
Individual Deductible	$3,500 In-network/$7,000 Out-of-network	$2,000 In-network/$4,000 Out-of-network	$3,500 In-network/$7,000 Out-of-network
Family Deductible	$7,000 In-network/$14,000 Out-of-network	$4,000 In-network/$8,000 Out-of-network	$7,000 In-network/$14,000 Out-of-network
Coinsurance	70% In-network/40% Out-of-network	80% In-network/50% Out-of-network	70% In-network/40% Out-of-network
Total Ind Plan OOP Maximum	$8,550 In-network/$25,650 Out-of-network	$6,600 In-network/$19,800 Out-of-network	$7,000 In-network/$21,000 Out-of-network
Total Fam Plan OOP Maximum	$17,100 In-network/$51,300 Out-of-network	$13,200 In-network/$39,600 Out-of-network	$14,000 In-network/$42,000 Out-of-network
Family Deductible Accumulation Method	Individual/Family deductible	Individual/Family deductible	Individual/Family deductible
PCP/Specialist Visit	$40/$60 copay, then covered at 100%	$35/$50 copay, then covered at 100%	Deductible and coinsurance
Teladoc®	No charge	No charge	No charge
Urgent Care Visit	$75 copay, then covered at 100%	$75 copay, then covered at 100%	Deductible and coinsurance
Medical Network	Cigna LocalPlus	Cigna LocalPlus	Cigna LocalPlus
OP Surgery	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance
Pharmacy Benefit Manager	CIGNA PBM	CIGNA PBM	CIGNA PBM
Rx Coverage (Generic/Brand/Non-preferred brand)	$20/$65/$100	$20/$50/$75	Deductible and 70% for generic 70% for brand 50% for non-preferred brand
DXL	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance
ER Treatment	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance
AME	N/A	N/A	N/A
Deductible and OOP Accrual Period	Calendar Year, deductible credit included	Calendar Year, deductible credit included	Calendar Year, deductible credit included
Run Out Period	6 months	6 months	6 months
Delayed Administration Fee	50%	50%	50%
HSA Eligible	No	No	Yes
Wellness Program	No	No	No
Dental	No	No	No
Total Cost	$6,667.55	$7,496.96	$6,344.76

Plan Selection Notes:

- Total plan out-of-pocket maximum includes deductible, coinsurance and any Rx or Medical copayments.
- This self-funded health benefit plan template meets Minimum Value.
- Plan includes Terminal Liability coverage for 24 months after the end of the plan year. A terminal liability coverage reserve fee will be taken at the end of the run-out, calculated as 3% of any remaining claim account surplus prior to any claim account refund. Terminal

The Allstate Benefits Self-Funded Program provides tools for small to mid-sized businesses to establish a self-funded health benefit plan for their employees. The benefit plan is established by the employer and is not an insurance product. For employers in the Allstate Benefits Self-Funded Program, stop-loss insurance is underwritten by Integon National Insurance Company in CT, NY and VT; Integon Indemnity Corporation in FL; and National Health Insurance Company in all other states where offered.

Group Name: TEACH, Inc.
Effective Date: 10/01/2021
SIC Code: 82100
Location Name: Location 1 Zip Code: 89130
Location Type: Main

Plan/Rate Summary

Please review this proposal. If you are ready to move forward, contact your Licensed Agent or Sales Representative to discuss the next steps.
Plans quoted in this proposal: 6

Liability coverage is not provided in cases of early termination.

- If claims are less than the aggregate deductible at the end of the run-out period, the employer may be eligible for a refund. Refund amounts, if any, are based on the refund selection at the time of issue or re-issue, as applicable. NOTE: Terminations prior to the end of the plan year will result in forfeiture of the remaining claim fund and no refund will be provided.

Allstate BENEFITS

Group Name: TEACH, Inc.
Effective Date: 10/01/2021
SIC Code: 82100
Location Name: Location 1 Zip Code: 89130
Location Type: Main

Plan/Rate Summary

Please review this proposal. If you are ready to move forward, contact your Licensed Agent or Sales Representative to discuss the next steps.
Plans quoted in this proposal: 6

Plan Name	Aetna PPO 1	Aetna PPO 2	Aetna HSA
Plan Type	Traditional	Traditional	Traditional
Medical Plan Design	SELF-FUNDED PPO COPAY PLAN	SELF-FUNDED PPO COPAY PLAN	SELF-FUNDED HSA PPO PLAN
Individual Deductible	$3,500 In-network/$7,000 Out-of-network	$2,000 In-network/$4,000 Out-of-network	$3,500 In-network/$7,000 Out-of-network
Family Deductible	$7,000 In-network/$14,000 Out-of-network	$4,000 In-network/$8,000 Out-of-network	$7,000 In-network/$14,000 Out-of-network
Coinsurance	70% In-network/50% Out-of-network	80% In-network/50% Out-of-network	70% In-network/50% Out-of-network
Total Ind Plan OOP Maximum	$8,550 In-network/$25,650 Out-of-network	$6,600 In-network/$19,800 Out-of-network	$7,000 In-network/$21,000 Out-of-network
Total Fam Plan OOP Maximum	$17,100 In-network/$51,300 Out-of-network	$13,200 In-network/$39,600 Out-of-network	$14,000 In-network/$42,000 Out-of-network
Family Deductible Accumulation Method	Individual/Family deductible	Individual/Family deductible	Individual/Family deductible
PCP/Specialist Visit	$40/$60 copay, then covered at 100%	$35/$50 copay, then covered at 100%	Deductible and coinsurance
Teladoc®	No charge	No charge	No charge
Urgent Care Visit	$75 copay, then covered at 100%	$75 copay, then covered at 100%	Deductible and coinsurance
Medical Network	Aetna Signature Administrators ® PPO	Aetna Signature Administrators ® PPO	Aetna Signature Administrators ® PPO
OP Surgery	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance
Pharmacy Benefit Manager	CIGNA PBM	CIGNA PBM	CIGNA PBM
Rx Coverage (Generic/Brand/Non-preferred brand)	$20/$65/$100	$20/$50/$75	Deductible and 70% for generic 70% for brand 50% for non-preferred brand
DXL	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance
ER Treatment	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance
AME	N/A	N/A	N/A
Deductible and OOP Accrual Period	Calendar Year, deductible credit included	Calendar Year, deductible credit included	Calendar Year, deductible credit included
Run Out Period	6 months	6 months	6 months
Delayed Administration Fee	50%	50%	50%
HSA Eligible	No	No	Yes
Wellness Program	No	No	No
Dental	No	No	No
Total Cost	$7,401.18	$8,691.51	$6,987.92

Plan Selection Notes:

- Total plan out-of-pocket maximum includes deductible, coinsurance and any Rx or Medical copayments.
- This self-funded health benefit plan template meets Minimum Value.
- Plan includes Terminal Liability coverage for 24 months after the end of the plan year. A terminal liability coverage reserve fee will be

The Allstate Benefits Self-Funded Program provides tools for small to mid-sized businesses to establish a self-funded health benefit plan for their employees. The benefit plan is established by the employer and is not an insurance product. For employers in the Allstate Benefits Self-Funded Program, stop-loss insurance is underwritten by Integon National Insurance Company in CT, NY and VT; Integon Indemnity Corporation in FL; and National Health Insurance Company in all other states where offered.

Allstate BENEFITS

Group Name: TEACH, Inc.
Effective Date: 10/01/2021
SIC Code: 82100
Location Name: Location 1 Zip Code: 89130
Location Type: Main

Plan/Rate Summary

Please review this proposal. If you are ready to move forward, contact your Licensed Agent or Sales Representative to discuss the next steps.
Plans quoted in this proposal: 6

taken at the end of the run-out, calculated as 3% of any remaining claim account surplus prior to any claim account refund. Terminal Liability coverage is not provided in cases of early termination.

- If claims are less than the aggregate deductible at the end of the run-out period, the employer may be eligible for a refund. Refund amounts, if any, are based on the refund selection at the time of issue or re-issue, as applicable. NOTE: Terminations prior to the end of the plan year will result in forfeiture of the remaining claim fund and no refund will be provided.

Allstate BENEFITS

Group Name: TEACH, Inc.
Effective Date: 10/01/2021
SIC Code: 82100
Location Name: Location 1
Zip Code: 89130
Location Type: Main

Stop-Loss Insurance and Financial Details			
	LocalPlus PPO	**LocalPlus PPO**	**LocalPlus HSA**
Specific Attachment Point	$40,000.00	$40,000.00	$40,000.00
Annual Aggregate Attachment Point	$44,000.76	$44,000.76	$44,000.76
Monthly Bill Medical			
Employee	$336.75	$378.64	$320.45
Employee + Spouse	$1,010.22	$1,135.90	$961.31
Employee + Child	$841.86	$946.58	$801.10
Family	$1,279.61	$1,438.80	$1,217.66
Stop-loss Premium	$1,562.22	$2,032.61	$1,411.06
Admin, Sales and General Expenses	$1,438.60	$1,797.62	$1,266.97
Claims Account	$3,666.73	$3,666.73	$3,666.73
Total	$6,667.55	$7,496.96	$6,344.76

Stop-Loss Insurance and Financial Details			
	Aetna PPO 1	**Aetna PPO 2**	**Aetna HSA**
Specific Attachment Point	$40,000.00	$40,000.00	$40,000.00
Annual Aggregate Attachment Point	$44,000.76	$46,319.76	$44,000.76
Monthly Bill Medical			
Employee	$373.80	$438.97	$352.93
Employee + Spouse	$1,121.38	$1,316.89	$1,058.76
Employee + Child	$934.49	$1,097.41	$882.31
Family	$1,420.42	$1,668.05	$1,341.10
Stop-loss Premium	$2,032.10	$2,656.93	$1,834.78
Admin, Sales and General Expenses	$1,702.35	$2,174.60	$1,486.41
Claims Account	$3,666.73	$3,859.98	$3,666.73
Total	$7,401.18	$8,691.51	$6,987.92

Allstate BENEFITS

Group Name: TEACH, Inc.
Effective Date: 10/01/2021
SIC Code: 82100
Location Name: Location 1 Zip Code: 89130
Location Type: Main

Self-Funded Dental Plan Options (Allied TPA only)

Self-funded dental is only available with medical coverage and is not a standalone product. The tables below illustrate the differences between dental plans and show pricing based on two separate network options. One dental plan and network may be purchased per employer. **Rates are subject to change based on enrollment.**

	Dental Plan Designs (only available with medical)			
Key Features	**Value Plan**	**Select Plan**	**Premier Plan**	**Choice Plan******
Individual Deductible^	$100 ($100)	$100 ($100)	$50 ($50)	$100
Preventive Services*	100% (60%) No Deductible	100% (70%) No Deductible	100% (70%) No Deductible	100% No Deductible
Basic Services**	80% (50%)	80% (60%)	90% (70%)	80%
Major Services***	Not covered	50% (40%)	50% (40%)	50%
Orthodontics	Not covered	Not covered	Not covered	Not covered
Annual Maximum	$1,500	$1,500	$1,500	$1,500
Waiting Period	None	None	None	None

	Dental Portion of Cost - Aetna Dental® Administrators			No Network
Tiered Rates	**Value Plan**	**Select Plan**	**Premier Plan**	**Choice Plan**
EE	$27.00	$34.71	$38.96	$52.59
ES	$80.99	$104.13	$116.89	$157.79
EC	$67.48	$86.77	$97.39	$131.48
Fam	$102.58	$131.90	$148.06	$199.86
Total Dental Cost †	$534.50	$687.24	$771.38	$1,041.32

	Dental Portion of Cost - Cigna Dental PPO SA			No Network
Tiered Rates	**Value Plan**	**Select Plan**	**Premier Plan**	**Choice Plan**
EE	$26.74	$34.38	$38.64	$52.59
ES	$80.20	$103.13	$115.92	$157.79
EC	$66.82	$85.94	$96.59	$131.48
Fam	$101.58	$130.64	$146.84	$199.86
Total Dental Cost †	$529.30	$680.68	$765.04	$1,041.32

Key

† Total Dental Cost is calculated off the census information from the medical quote and assumes no one waives dental coverage. The official quote may have minor rounding differences.

^ ( ) Out of network value

* Routine exams, cleanings (6 months), fluoride treatments, sealants, bitewing x-rays

** Minor Restorative Services - Fillings, extractions, etc.

*** Replacement of prosthodontics, dentures, crowns, and inlays, endodontic procedures, periodontics procedures, major restorative procedures, oral surgery

**** No network used for Out of Network (OON) and Choice Plans

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Allstate BENEFITS

Employee Census

Business Name: TEACH, Inc.
Agent: Rob Stenzel
Agent Phone: (310) 270-8744
Proposal Creation Date: 09/09/2021

County: CLARK
State: NV ZIP 89130
Proposed Effective Date: 10/01/2021 Size Category: S

HCR Indicator:
Location Name: Location 1
Location Type: Main
SIC Code: 82100

Total Employees: 11 **Total Employees Eligible:** 11 **Total Employees Enrolling:** 11

Medical	LocalPlus PPO 1		LocalPlus PPO 2		LocalPlus HSA		Aetna PPO 1	
	Rate	Enrollment	Rate	Enrollment	Rate	Enrollment	Rate	Enrollment
Employee (EE)	$336.75	6	$378.64	6	$320.45	6	$373.80	6
Employee + Spouse (EE+SP)	$1,010.22	0	$1,135.90	0	$961.31	0	$1,121.38	0
Employee + Child (EE+CH)	$841.86	4	$946.58	4	$801.10	4	$934.49	4
Employee + Family (EE+FM)	$1,279.61	1	$1,438.80	1	$1,217.66	1	$1,420.42	1

Medical	Aetna PPO 2		Aetna HSA	
	Rate	Enrollment	Rate	Enrollment
Employee (EE)	$438.97	6	$352.93	6
Employee + Spouse (EE+SP)	$1,316.89	0	$1,058.76	0
Employee + Child (EE+CH)	$1,097.41	4	$882.31	4
Employee + Family (EE+FM)	$1,668.05	1	$1,341.10	1

Monthly Rate Breakdown by Employee				
Member Name	LocalPlus PPO 1 Cost	LocalPlus PPO 2 Cost	LocalPlus HSA Cost	Aetna PPO 1 Cost
Moore, Andrea F(50), CH: 2	$841.86	$946.58	$801.10	$934.49
Piet, Gina F(47), CH: 3	$841.86	$946.58	$801.10	$934.49
Aab, Tiffany F(45), CH: 1	$841.86	$946.58	$801.10	$934.49
O'Rane , Forrester F(32)	$336.75	$378.64	$320.45	$373.80
Strickland, Katie F(26)	$336.75	$378.64	$320.45	$373.80
Chavez, Harmony F(44)	$336.75	$378.64	$320.45	$373.80
Davis, Megan F(38), CH: 1	$841.86	$946.58	$801.10	$934.49
Moore, Benjamin M(19)	$336.75	$378.64	$320.45	$373.80
Terranova, Samantha F(22)	$336.75	$378.64	$320.45	$373.80
Hubble, Nicole F(36)	$336.75	$378.64	$320.45	$373.80
Metzel, Tricia F(43), SP M(49), CH: 2	$1,279.61	$1,438.80	$1,217.66	$1,420.42
Monthly Total	$6,667.55	$7,496.96	$6,344.76	$7,401.18

Allstate BENEFITS

Employee Census

Business Name: TEACH, Inc.
Agent: Rob Stenzel
Agent Phone: (310) 270-8744
Proposal Creation Date: 09/09/2021

County: CLARK
State: NV ZIP 89130
Proposed Effective Date: 10/01/2021 Size Category: S

HCR Indicator:
Location Name: Location 1
Location Type: Main
SIC Code: 82100

Total Employees: 11 **Total Employees Eligible:** 11 **Total Employees Enrolling:** 11

Monthly Rate Breakdown by Employee		
Member Name	**Aetna PPO 2 Cost**	**Aetna HSA Cost**
Moore, Andrea F(50), CH: 2	$1,097.41	$882.31
Piet, Gina F(47), CH: 3	$1,097.41	$882.31
Aab, Tiffany F(45), CH: 1	$1,097.41	$882.31
O'Rane , Forrester F(32)	$438.97	$352.93
Strickland, Katie F(26)	$438.97	$352.93
Chavez, Harmony F(44)	$438.97	$352.93
Davis, Megan F(38), CH: 1	$1,097.41	$882.31
Moore, Benjamin M(19)	$438.97	$352.93
Terranova, Samantha F(22)	$438.97	$352.93
Hubble, Nicole F(36)	$438.97	$352.93
Metzel, Tricia F(43), SP M(49), CH: 2	$1,668.05	$1,341.10
Monthly Total	$8,691.51	$6,987.92

Allstate BENEFITS

Benefit Summary

Business Name: TEACH, Inc.
Agent: Rob Stenzel
Agent Phone: (310) 270-8744
Proposal Creation Date: 09/09/2021
County: CLARK
State: NV ZIP 89130
Proposed Effective Date: 10/01/2021
Size Category: S
HCR Indicator:
Location Name: Location 1
Location Type: Main
SIC Code: 82100

LocalPlus PPO 1	
Plan type: Self-funded PPO, Level-funded plan	
Medical Network	Cigna LocalPlus www.cigna.com
Individual Deductible	$3,500 In-network/$7,000 Out-of-network
Family Deductible	$7,000 In-network/$14,000 Out-of-network
Family Deductible Accumulation Method	Individual/Family deductible
Plan Coinsurance Percentage (plan pays)	70% In-network/40% Out-of-network
Individual Coinsurance out-of-pocket maximum (family coinsurance out-of-pocket maximum is 2 x the individual coinsurance out-of-pocket maximum)	$5,050 In-network/$18,650 Out-of-network
Total Individual out-of-pocket maximum	$8,550 In-network/$25,650 Out-of-network
Total Family out-of-pocket maximum	$17,100 In-network/$51,300 Out-of-network
Lifetime Benefit Maximum	No maximum
Office Visit * (does not require a referral)	$40 primary care provider copay, then covered at 100%/$60 specialist copay, then covered at 100%
Teladoc® Access to a national network of U.S. board-certified doctors and pediatricians who are available 24/7 to diagnose, treat and prescribe medication (when necessary) for many medical issues via phone or online video consultations.	No charge
Pharmacy Benefit Manager	CIGNA PBM
Prescription Drugs Generic copay/Preferred brand copay/Nonpreferred brand copay (Mail order services included)	$20/$65/$100
Clinical Preventive Services: Services recommended by the U.S. Preventive Services Task Force (USPSTF) including routine physical exams, associated imaging and laboratory services such as mammograms, well-child exams and immunizations. *	Paid at 100% - no deductible, coinsurance
Urgent Care Visit *	$75 copay, then covered at 100%
Diagnostic X-ray and Laboratory services *	Deductible and coinsurance
MRI, CT scan, PET scan Ultrasound, EKG, chemotherapy, radiation therapy, dialysis and BRCA	Deductible and coinsurance
Emergency Room Treatment Subject to a 30% penalty for non-emergency use *	Deductible and coinsurance
Maternity	Deductible and coinsurance

The Allstate Benefits Self-Funded Program provides tools for small to mid-sized businesses to establish a self-funded health benefit plan for their employees. The benefit plan is established by the employer and is not an insurance product. For employers in the Allstate Benefits Self-Funded Program, stop-loss insurance is underwritten by Integon National Insurance Company in CT, NY and VT; Integon Indemnity Corporation in FL; and National Health Insurance Company in all other states where offered.

Allstate BENEFITS

Benefit Summary

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SIC Code: 82100

Outpatient Physical Medicine Includes physical, speech and occupational therapies, cardiac and pulmonary rehabilitation, treatment for development delay and Chiropractic care.	Deductible and coinsurance limited to 30 visits
Home Health Care	Limited to 60 visits
Subacute Rehabilitation and Nursing Facility Services	Limited to 31 days combined
Inpatient Rehabilitation Services	Limited to 31 days
Transplants Covered the same as any other service when performed by a designated provider.	Deductible and coinsurance
Behavioral Health and Substance Abuse for groups with 50 employees and less.	Inpatient: limited to 30 days. Inpatient and Outpatient: subject to deductible and 70% coinsurance. Outpatient: limited to 40 visits.
Behavioral Health and Substance Abuse for groups with 51 or more employees.	Inpatient and Outpatient: subject to plan deductible and plan coinsurance.
Inpatient and Outpatient Hospital*, Physician Services, Maternity Care, Ambulance, Durable Medical Equipment, and most other covered services	Deductible and coinsurance

***Services performed by an out-of-network provider are subject to the out-of-network deductible and coinsurance.**

Allstate BENEFITS

Benefit Summary

Business Name: TEACH, Inc.
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Size Category: S
HCR Indicator:
Location Name: Location 1
Location Type: Main
SIC Code: 82100

LocalPlus PPO 2	
Plan type: Self-funded PPO, Level-funded plan	
Medical Network	Cigna LocalPlus www.cigna.com
Individual Deductible	$2,000 In-network/$4,000 Out-of-network
Family Deductible	$4,000 In-network/$8,000 Out-of-network
Family Deductible Accumulation Method	Individual/Family deductible
Plan Coinsurance Percentage (plan pays)	80% In-network/50% Out-of-network
Individual Coinsurance out-of-pocket maximum (family coinsurance out-of-pocket maximum is 2 x the individual coinsurance out-of-pocket maximum)	$4,600 In-network/$15,800 Out-of-network
Total Individual out-of-pocket maximum	$6,600 In-network/$19,800 Out-of-network
Total Family out-of-pocket maximum	$13,200 In-network/$39,600 Out-of-network
Lifetime Benefit Maximum	No maximum
Office Visit * (does not require a referral)	$35 primary care provider copay, then covered at 100%/$50 specialist copay, then covered at 100%
Teladoc® Access to a national network of U.S. board-certified doctors and pediatricians who are available 24/7 to diagnose, treat and prescribe medication (when necessary) for many medical issues via phone or online video consultations.	No charge
Pharmacy Benefit Manager	CIGNA PBM
Prescription Drugs Generic copay/Preferred brand copay/Nonpreferred brand copay (Mail order services included)	$20/$50/$75
Clinical Preventive Services: Services recommended by the U.S. Preventive Services Task Force (USPSTF) including routine physical exams, associated imaging and laboratory services such as mammograms, well-child exams and immunizations. *	Paid at 100% - no deductible, coinsurance
Urgent Care Visit *	$75 copay, then covered at 100%
Diagnostic X-ray and Laboratory services *	Deductible and coinsurance
MRI, CT scan, PET scan Ultrasound, EKG, chemotherapy, radiation therapy, dialysis and BRCA	Deductible and coinsurance
Emergency Room Treatment Subject to a 30% penalty for non-emergency use *	Deductible and coinsurance
Maternity	Deductible and coinsurance

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Outpatient Physical Medicine Includes physical, speech and occupational therapies, cardiac and pulmonary rehabilitation, treatment for development delay and Chiropractic care.	Deductible and coinsurance limited to 30 visits
Home Health Care	Limited to 60 visits
Subacute Rehabilitation and Nursing Facility Services	Limited to 31 days combined
Inpatient Rehabilitation Services	Limited to 31 days
Transplants Covered the same as any other service when performed by a designated provider.	Deductible and coinsurance
Behavioral Health and Substance Abuse for groups with 50 employees and less.	Inpatient: limited to 30 days. Inpatient and Outpatient: subject to deductible and 70% coinsurance. Outpatient: limited to 40 visits.
Behavioral Health and Substance Abuse for groups with 51 or more employees.	Inpatient and Outpatient: subject to plan deductible and plan coinsurance.
Inpatient and Outpatient Hospital*, Physician Services, Maternity Care, Ambulance, Durable Medical Equipment, and most other covered services	Deductible and coinsurance

***Services performed by an out-of-network provider are subject to the out-of-network deductible and coinsurance.**

The Allstate Benefits Self-Funded Program provides tools for small to mid-sized businesses to establish a self-funded health benefit plan for their employees. The benefit plan is established by the employer and is not an insurance product. For employers in the Allstate Benefits Self-Funded Program, stop-loss insurance is underwritten by Integon National Insurance Company in CT, NY and VT; Integon Indemnity Corporation in FL; and National Health Insurance Company in all other states where offered.

Allstate BENEFITS

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Location Name: Location 1
Location Type: Main
SIC Code: 82100

LocalPlus HSA	
Plan type: Self-funded PPO, Level-funded plan	
Medical Network	Cigna LocalPlus www.cigna.com
Individual Deductible	$3,500 In-network/$7,000 Out-of-network
Family Deductible	$7,000 In-network/$14,000 Out-of-network
Family Deductible Accumulation Method	Individual/Family deductible
Plan Coinsurance Percentage (plan pays)	70% In-network/40% Out-of-network
Individual Coinsurance out-of-pocket maximum (family coinsurance out-of-pocket maximum is 2 x the individual coinsurance out-of-pocket maximum)	$3,500 In-network/$14,000 Out-of-network
Total Individual out-of-pocket maximum	$7,000 In-network/$21,000 Out-of-network
Total Family out-of-pocket maximum	$14,000 In-network/$42,000 Out-of-network
Lifetime Benefit Maximum	No maximum
Office Visit * (does not require a referral)	Deductible and coinsurance
Teladoc® Access to a national network of U.S. board-certified doctors and pediatricians who are available 24/7 to diagnose, treat and prescribe medication (when necessary) for many medical issues via phone or online video consultations.	No charge
Pharmacy Benefit Manager	CIGNA PBM
Prescription Drugs When generic is available, but a non-preferred brand is purchased, the member will be responsible for the difference in price. (Mail order services included)	Deductible and 70% for generic 70% for brand 50% for non-preferred brand
Clinical Preventive Services: Services recommended by the U.S. Preventive Services Task Force (USPSTF) including routine physical exams, associated imaging and laboratory services such as mammograms, well-child exams and immunizations. *	Paid at 100% - no deductible, coinsurance
Urgent Care Visit *	Deductible and coinsurance
Diagnostic X-ray and Laboratory services *	Deductible and coinsurance
MRI, CT scan, PET scan Ultrasound, EKG, chemotherapy, radiation therapy, dialysis and BRCA	Deductible and coinsurance
Emergency Room Treatment Subject to a 30% penalty for non-emergency use *	Deductible and coinsurance
Maternity	Deductible and coinsurance

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Allstate BENEFITS

Benefit Summary

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Size Category: S
HCR Indicator:
Location Name: Location 1
Location Type: Main
SIC Code: 82100

Outpatient Physical Medicine Includes physical, speech and occupational therapies, cardiac and pulmonary rehabilitation, treatment for development delay and Chiropractic care.	Deductible and coinsurance limited to 30 visits
Home Health Care	Limited to 60 visits
Subacute Rehabilitation and Nursing Facility Services	Limited to 31 days combined
Inpatient Rehabilitation Services	Limited to 31 days
Transplants Covered the same as any other service when performed by a designated provider.	Deductible and coinsurance
Behavioral Health and Substance Abuse for groups with 50 employees and less.	Inpatient: limited to 30 days. Inpatient and Outpatient: subject to deductible and 70% coinsurance. Outpatient: limited to 40 visits.
Behavioral Health and Substance Abuse for groups with 51 or more employees.	Inpatient and Outpatient: subject to plan deductible and plan coinsurance.
Inpatient and Outpatient Hospital*, Physician Services, Maternity Care, Ambulance, Durable Medical Equipment, and most other covered services	Deductible and coinsurance

***Services performed by an out-of-network provider are subject to the out-of-network deductible and coinsurance.**

The Allstate Benefits Self-Funded Program provides tools for small to mid-sized businesses to establish a self-funded health benefit plan for their employees. The benefit plan is established by the employer and is not an insurance product. For employers in the Allstate Benefits Self-Funded Program, stop-loss insurance is underwritten by Integon National Insurance Company in CT, NY and VT; Integon Indemnity Corporation in FL; and National Health Insurance Company in all other states where offered.

Allstate BENEFITS

Benefit Summary

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Size Category: S
HCR Indicator:
Location Name: Location 1
Location Type: Main
SIC Code: 82100

Aetna PPO 1	
Plan type: Self-funded PPO, Level-funded plan	
Medical Network	Aetna Signature Administrators ® PPO www.aetna.com/asa
Individual Deductible	$3,500 In-network/$7,000 Out-of-network
Family Deductible	$7,000 In-network/$14,000 Out-of-network
Family Deductible Accumulation Method	Individual/Family deductible
Plan Coinsurance Percentage (plan pays)	70% In-network/50% Out-of-network
Individual Coinsurance out-of-pocket maximum (family coinsurance out-of-pocket maximum is 2 x the individual coinsurance out-of-pocket maximum)	$5,050 In-network/$18,650 Out-of-network
Total Individual out-of-pocket maximum	$8,550 In-network/$25,650 Out-of-network
Total Family out-of-pocket maximum	$17,100 In-network/$51,300 Out-of-network
Lifetime Benefit Maximum	No maximum
Office Visit * (does not require a referral)	$40 primary care provider copay, then covered at 100%/$60 specialist copay, then covered at 100%
Teladoc® Access to a national network of U.S. board-certified doctors and pediatricians who are available 24/7 to diagnose, treat and prescribe medication (when necessary) for many medical issues via phone or online video consultations.	No charge
Pharmacy Benefit Manager	CIGNA PBM
Prescription Drugs Generic copay/Preferred brand copay/Nonpreferred brand copay (Mail order services included)	$20/$65/$100
Clinical Preventive Services: Services recommended by the U.S. Preventive Services Task Force (USPSTF) including routine physical exams, associated imaging and laboratory services such as mammograms, well-child exams and immunizations. *	Paid at 100% - no deductible, coinsurance
Urgent Care Visit *	$75 copay, then covered at 100%
Diagnostic X-ray and Laboratory services *	Deductible and coinsurance
MRI, CT scan, PET scan Ultrasound, EKG, chemotherapy, radiation therapy, dialysis and BRCA	Deductible and coinsurance
Emergency Room Treatment Subject to a 30% penalty for non-emergency use *	Deductible and coinsurance

The Allstate Benefits Self-Funded Program provides tools for small to mid-sized businesses to establish a self-funded health benefit plan for their employees. The benefit plan is established by the employer and is not an insurance product. For employers in the Allstate Benefits Self-Funded Program, stop-loss insurance is underwritten by Integon National Insurance Company in CT, NY and VT; Integon Indemnity Corporation in FL; and National Health Insurance Company in all other states where offered.

Allstate BENEFITS

Benefit Summary

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Proposed Effective Date: 10/01/2021
Size Category: S
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Location Name: Location 1
Location Type: Main
SIC Code: 82100

Maternity	Deductible and coinsurance
Outpatient Physical Medicine Includes physical, speech and occupational therapies, cardiac and pulmonary rehabilitation, treatment for development delay and Chiropractic care.	Deductible and coinsurance limited to 30 visits
Home Health Care	Limited to 60 visits
Subacute Rehabilitation and Nursing Facility Services	Limited to 31 days combined
Inpatient Rehabilitation Services	Limited to 31 days
Transplants Covered the same as any other service when performed by a designated provider.	Deductible and coinsurance
Behavioral Health and Substance Abuse for groups with 50 employees and less.	Inpatient: limited to 30 days. Inpatient and Outpatient: subject to deductible and 50% coinsurance. Outpatient: limited to 40 visits.
Behavioral Health and Substance Abuse for groups with 51 or more employees.	Inpatient and Outpatient: subject to plan deductible and plan coinsurance.
Inpatient and Outpatient Hospital*, Physician Services, Maternity Care, Ambulance, Durable Medical Equipment, and most other covered services	Deductible and coinsurance

***Services performed by an out-of-network provider are subject to the out-of-network deductible and coinsurance.**

The Allstate Benefits Self-Funded Program provides tools for small to mid-sized businesses to establish a self-funded health benefit plan for their employees. The benefit plan is established by the employer and is not an insurance product. For employers in the Allstate Benefits Self-Funded Program, stop-loss insurance is underwritten by Integon National Insurance Company in CT, NY and VT; Integon Indemnity Corporation in FL; and National Health Insurance Company in all other states where offered.

Allstate BENEFITS

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Size Category: S
HCR Indicator:
Location Name: Location 1
Location Type: Main
SIC Code: 82100

Aetna PPO 2	
Plan type: Self-funded PPO, Level-funded plan	
Medical Network	Aetna Signature Administrators ® PPO www.aetna.com/asa
Individual Deductible	$2,000 In-network/$4,000 Out-of-network
Family Deductible	$4,000 In-network/$8,000 Out-of-network
Family Deductible Accumulation Method	Individual/Family deductible
Plan Coinsurance Percentage (plan pays)	80% In-network/50% Out-of-network
Individual Coinsurance out-of-pocket maximum (family coinsurance out-of-pocket maximum is 2 x the individual coinsurance out-of-pocket maximum)	$4,600 In-network/$15,800 Out-of-network
Total Individual out-of-pocket maximum	$6,600 In-network/$19,800 Out-of-network
Total Family out-of-pocket maximum	$13,200 In-network/$39,600 Out-of-network
Lifetime Benefit Maximum	No maximum
Office Visit * (does not require a referral)	$35 primary care provider copay, then covered at 100%/$50 specialist copay, then covered at 100%
Teladoc® Access to a national network of U.S. board-certified doctors and pediatricians who are available 24/7 to diagnose, treat and prescribe medication (when necessary) for many medical issues via phone or online video consultations.	No charge
Pharmacy Benefit Manager	CIGNA PBM
Prescription Drugs Generic copay/Preferred brand copay/Nonpreferred brand copay (Mail order services included)	$20/$50/$75
Clinical Preventive Services: Services recommended by the U.S. Preventive Services Task Force (USPSTF) including routine physical exams, associated imaging and laboratory services such as mammograms, well-child exams and immunizations. *	Paid at 100% - no deductible, coinsurance
Urgent Care Visit *	$75 copay, then covered at 100%
Diagnostic X-ray and Laboratory services *	Deductible and coinsurance
MRI, CT scan, PET scan Ultrasound, EKG, chemotherapy, radiation therapy, dialysis and BRCA	Deductible and coinsurance
Emergency Room Treatment Subject to a 30% penalty for non-emergency use *	Deductible and coinsurance

The Allstate Benefits Self-Funded Program provides tools for small to mid-sized businesses to establish a self-funded health benefit plan for their employees. The benefit plan is established by the employer and is not an insurance product. For employers in the Allstate Benefits Self-Funded Program, stop-loss insurance is underwritten by Integon National Insurance Company in CT, NY and VT; Integon Indemnity Corporation in FL; and National Health Insurance Company in all other states where offered.

Allstate BENEFITS

Benefit Summary

Business Name: TEACH, Inc.
Agent: Rob Stenzel
Agent Phone: (310) 270-8744
Proposal Creation Date: 09/09/2021
County: CLARK
State: NV ZIP 89130
Proposed Effective Date: 10/01/2021
Size Category: S
HCR Indicator:
Location Name: Location 1
Location Type: Main
SIC Code: 82100

Maternity	Deductible and coinsurance
Outpatient Physical Medicine Includes physical, speech and occupational therapies, cardiac and pulmonary rehabilitation, treatment for development delay and Chiropractic care.	Deductible and coinsurance limited to 30 visits
Home Health Care	Limited to 60 visits
Subacute Rehabilitation and Nursing Facility Services	Limited to 31 days combined
Inpatient Rehabilitation Services	Limited to 31 days
Transplants Covered the same as any other service when performed by a designated provider.	Deductible and coinsurance
Behavioral Health and Substance Abuse for groups with 50 employees and less.	Inpatient: limited to 30 days. Inpatient and Outpatient: subject to deductible and 50% coinsurance. Outpatient: limited to 40 visits.
Behavioral Health and Substance Abuse for groups with 51 or more employees.	Inpatient and Outpatient: subject to plan deductible and plan coinsurance.
Inpatient and Outpatient Hospital*, Physician Services, Maternity Care, Ambulance, Durable Medical Equipment, and most other covered services	Deductible and coinsurance

***Services performed by an out-of-network provider are subject to the out-of-network deductible and coinsurance.**

The Allstate Benefits Self-Funded Program provides tools for small to mid-sized businesses to establish a self-funded health benefit plan for their employees. The benefit plan is established by the employer and is not an insurance product. For employers in the Allstate Benefits Self-Funded Program, stop-loss insurance is underwritten by Integon National Insurance Company in CT, NY and VT; Integon Indemnity Corporation in FL; and National Health Insurance Company in all other states where offered.

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Aetna HSA	
Plan type: Self-funded PPO, Level-funded plan	
Medical Network	Aetna Signature Administrators ® PPO www.aetna.com/asa
Individual Deductible	$3,500 In-network/$7,000 Out-of-network
Family Deductible	$7,000 In-network/$14,000 Out-of-network
Family Deductible Accumulation Method	Individual/Family deductible
Plan Coinsurance Percentage (plan pays)	70% In-network/50% Out-of-network
Individual Coinsurance out-of-pocket maximum (family coinsurance out-of-pocket maximum is 2 x the individual coinsurance out-of-pocket maximum)	$3,500 In-network/$14,000 Out-of-network
Total Individual out-of-pocket maximum	$7,000 In-network/$21,000 Out-of-network
Total Family out-of-pocket maximum	$14,000 In-network/$42,000 Out-of-network
Lifetime Benefit Maximum	No maximum
Office Visit * (does not require a referral)	Deductible and coinsurance
Teladoc® Access to a national network of U.S. board-certified doctors and pediatricians who are available 24/7 to diagnose, treat and prescribe medication (when necessary) for many medical issues via phone or online video consultations.	No charge
Pharmacy Benefit Manager	CIGNA PBM
Prescription Drugs When generic is available, but a non-preferred brand is purchased, the member will be responsible for the difference in price. (Mail order services included)	Deductible and 70% for generic 70% for brand 50% for non-preferred brand
Clinical Preventive Services: Services recommended by the U.S. Preventive Services Task Force (USPSTF) including routine physical exams, associated imaging and laboratory services such as mammograms, well-child exams and immunizations. *	Paid at 100% - no deductible, coinsurance
Urgent Care Visit *	Deductible and coinsurance
Diagnostic X-ray and Laboratory services *	Deductible and coinsurance
MRI, CT scan, PET scan Ultrasound, EKG, chemotherapy, radiation therapy, dialysis and BRCA	Deductible and coinsurance
Emergency Room Treatment Subject to a 30% penalty for non-emergency use *	Deductible and coinsurance
Maternity	Deductible and coinsurance

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Behavioral Health and Substance Abuse for groups with 51 or more employees.	Inpatient and Outpatient: subject to plan deductible and plan coinsurance.
Inpatient and Outpatient Hospital*, Physician Services, Maternity Care, Ambulance, Durable Medical Equipment, and most other covered services	Deductible and coinsurance

***Services performed by an out-of-network provider are subject to the out-of-network deductible and coinsurance.**

The following information applies to all the plans contained in this Proposal:

Additional Information

Utilization Review

When inpatient treatment is needed, the covered person is responsible for calling to receive authorization. The toll-free telephone number appears on the insurance ID card. If authorization is not received, a penalty will be applied. Please refer to the SPD for specific details. No benefits are paid for transplants which are not authorized. Authorization is not a guarantee of coverage.

Deductible Credit

When coverage first begins, credit is given for any portion of a calendar-year deductible satisfied under the prior plan during the same calendar year, except when the deductible credit is waived. However, no credit is given for past policy-year deductibles.

If a dental option is selected, deductible credit may also be available.

New Hires

For groups with a 0, 30 or 60 day employment waiting period, new eligible employees and their dependents, upon satisfaction of the employment waiting period, are eligible for the following effective date: First day of the billing month following the date of full-time employment, when the enrollment request is received within 31 days of this date. For groups with a 90 day employment waiting period, newly eligible employees and their dependents, upon satisfaction of the employment waiting period, are eligible for the following effective date: The 90th day following the date of full-time employment, when the enrollment request is received within 31 days of the expiration of the employment waiting period.

If a dental option is selected, the same new hire waiting period will apply.

Medical Exclusions Summary

- For Advantage plans, any charges that are provided or performed by a Health Care Practitioner, facility, or supplier that is not identified for the Health Care Provider Network as a Participating Provider, Participating Pharmacy, Specialty Pharmacy Provider, or Designated Transplant Provider. This exclusion does not apply to PPO plans that cover charges for treatment provided or performed by either Participating Providers (In-network) or Non-Participating Providers (Out-of-network).
- Treatment not listed in the summary plan description
- Services by a medical provider who is an immediate family member or who resides with a covered person
- Charges for services, supplies or drugs provided by or through any employer of a Covered Person or of a Covered Person's family member
- Treatment reimbursable by Medicare, Workers' Compensation, automobile carriers or expenses for which other coverage is available
- Routine hearing care, vision therapy, surgery to correct vision, foot orthotics, or routine vision care and foot care unless part of the diabetic treatment
- Charges for custodial care, private nursing, telemedicine or phone consultations with the exception of Teladoc® services if purchased as part of your plan, or Telehealth (virtual) visits
- Charges for diagnosis and treatment of infertility except for groups of 51 or more that are administered by Allied or Meritain on the traditional or Advantage plans
- Charges for surrogate pregnancy or sterilization reversal
- Charges for cosmetic services, including chemical peels, plastic surgery and medications
- Charges for umbilical cord storage, genetic testing, counseling and services
- Treatment of "quality Of life" or "lifestyle"concerns including but not limited to obesity, hair loss, restoration or promotion of sexual function, cognitive enhancement and educational testing or training
- Over-the-counter drugs, (unless recommended by the United States Preventive Services Task Force and authorized by a health care provider), drugs not approved by the FDA, drugs obtained from sources outside the United States, and the difference in cost between a generic and brand name drug when the generic is available
- Complications of an excluded service
- Charges in excess of any stated benefit maximum
- Treatment of an illness or injury caused by acts of war, felony, or influence of an illegal substance
- Dental care not related to a dental injury (specific to medical coverage)
- Non-surgical treatment for TMJ or CMJ other than that described in the contract, or any related surgical treatment that is not pre-authorized
- Any correction of malocclusion, protrusion, hypoplasia or hyperplasia of the jaws
- Charges for cranial orthotic devices, except following cranial surgery
- Charges for medical devices designed to be used at home, except as otherwise covered in the Durable Medical Equipment and Personal Medical Equipment provision or the Diabetic Services provision in the Medical Benefits section
- Charges for devices or supplies, except as described under a Prescription Order
- Charges for prophylactic treatment
- Charges related to health care practitioner-assisted suicide
- Charges for growth hormone stimulation treatment to promote or delay growth
- Charges for treatment of behavioral health or substance abuse, except as otherwise covered in the Behavioral Health and Substance Abuse provision in the Medical Benefits section
- Charges for testing and treatment related to the diagnosis of behavioral conduct or developmental problems; charges for applied behavioral analysis
- Charges for alternative medicine, including acupuncture and naturopathic medicine (except when optional acupuncture and naturopathic medicine coverage is purchased)
- Charges for chelation therapy
- Charges for experimental or investigational services

This form contains a partial summary of information for the health benefit plan templates. For a complete listing of employee health benefits, exclusions and limitations please refer to the summary plan description. Please refer to the stop-loss policy for a complete listing of employer stop-loss benefits, exclusions and terms of coverage. In the event that there are discrepancies with the information in this form, the terms and conditions of the coverage documents will govern.

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Benefit Sheet

	Blue Shield Bronze Tandem PPO Savings 5300/40% OffEx (Narrow Network)	
Benefit	**In Network**	**Out of Network**
Individual Ded	$5,300	$10,600
Family Ded	$10,600 (embedded)	$21,200 (embedded)
Individual OOP Max	$6,900 (incl ded)	$13,800 (incl ded)
Family OOP Max	$13,800 (incl ded)	$27,600 (incl ded)
Co-insurance	40%	50%
Lifetime Max	Unlimited	Unlimited
PC/Specialist	40% after ded	50% after ded
Adult Preventive Care	No charge	Not covered
Child Preventive Care	No charge	Not covered
Pre/Postnatal Care	No charge	50% after ded
Physical Therapy	40% after ded	50% after ded
Chiropractic Care	50% after ded; 20 visits/cal yr	50% after ded; 20 visits/cal yr
Inpatient Hospital	40% after ded	50% after ded; $2,000 benefit max/day
Inpatient Surgery	40% after ded	50% after ded
Maternity Delivery/IP	40% after ded	50% after ded
Mental Health IP	40% after ded	50% after ded; $2,000 benefit max/day
Substance Abuse IP	40% after ded	50% after ded; $2,000 benefit max/day
Outpatient Facility	40% after ded/$200 + 40% after ded (ASC/Hospital)	50% after ded; $350 benefit max/day
Outpatient Surgery	40% after ded	50% after ded
Lab/X-Ray	40% after ded	50% after ded; $350 benefit max/day Hospital
Advanced Radiology	40% after ded/$100 + 40% after ded (FS/Hospital)	50% after ded; $350 benefit max/day Hospital
Mental Health OP	40% after ded	50% after ded
Substance Abuse OP	40% after ded	50% after ded
Emergency Room	$250 (waived if admitted) + 40% after ded	$250 (waived if admitted) + 40% after ded
Ambulance	40% after ded	40% after ded
Urgent Care	40% after ded	50% after ded
Rx Generic	40% after ded; $500 max/script	Not covered
Rx Preferred	40% after ded; $500 max/script	Not covered
Rx Non-Preferred	40% after ded; $500 max/script	Not covered
Rx Specialty	40% after ded; $500 max/script	Not covered
Rx Mail Order	2x retail copay	Not covered
Home Health Care	40% after ded; 100 visits/cal yr	Not covered
Skilled Nursing	40% after ded; 100 days/benefit period	40%/50% after ded (FS/Hosp); $2,000 benefit max/day Hosp; 100 days/benefit period
Infertility Treatment	Not covered	Not covered
DME	50% after ded	Not covered
Hospice Services	0% after ded	Not covered
Pediatric Vision	Covered; See brochure	Covered; See brochure
Pediatric Dental	Covered; See brochure	Covered; See brochure

Benefit Sheet

	Blue Shield Gold Tandem PPO 1200/35 OffEx (Narrow Network)	
Benefit	**In Network**	**Out of Network**
Individual Ded	$1,200	$2,400
Family Ded	$2,400	$4,800
Individual OOP Max	$7,800 (incl ded)	$13,850 (incl ded)
Family OOP Max	$15,600 (incl ded)	$27,700 (incl ded)
Co-insurance	20%	40%
Lifetime Max	Unlimited	Unlimited
PC/Specialist	$35/$50 ded waived	40% after ded
Adult Preventive Care	No charge	Not covered
Child Preventive Care	No charge	Not covered
Pre/Postnatal Care	No charge	40% after ded
Physical Therapy	20% after ded	40% after ded
Chiropractic Care	$10 ded waived; 20 visits/cal yr	50% after ded; 20 visits/cal yr
Inpatient Hospital	20% after ded	40% after ded; $2,000 benefit max/day
Inpatient Surgery	20% after ded	40% after ded
Maternity Delivery/IP	20% after ded	40% after ded
Mental Health IP	20% after ded	40% after ded; $2,000 benefit max/day
Substance Abuse IP	20% after ded	40% after ded; $2,000 benefit max/day
Outpatient Facility	20% after ded/$150 + 20% after ded (ASC/Hospital)	40% after ded; $350 benefit max/day
Outpatient Surgery	20% after ded	40% after ded
Lab/X-Ray	L-$35 ded waived/20% after ded; X-$50/$100 ded waived (FS/Hospital)	40% after ded; $350 benefit max/day Hospital
Advanced Radiology	20% after ded/$100 + 20% after ded (FS/Hospital)	40% after ded; $350 benefit max/day Hospital
Mental Health OP	$35 ded waived	40% after ded
Substance Abuse OP	$35 ded waived	40% after ded
Emergency Room	$250 (waived if admitted) + 20% after ded	$250 (waived if admitted) + 20% after ded
Ambulance	20% after ded	20% after ded
Urgent Care	$35 ded waived	40% after ded
Rx Generic	$10/$15 ded waived	Not covered
Rx Preferred	$40/$60 after $300	Not covered
Rx Non-Preferred	$70/$100 after $300	Not covered
Rx Specialty	30% after $300; $250 max/script	Not covered
Rx Mail Order	2x retail copay	Not covered
Home Health Care	20% after ded; 100 visits/cal yr	Not covered
Skilled Nursing	20% after ded; 100 days/benefit period	20%/40% after ded (FS/Hosp); $2,000 benefit max/day Hosp; 100 days/benefit period
Infertility Treatment	Not covered	Not covered
DME	50% after ded	Not covered
Hospice Services	0% after ded	Not covered
Pediatric Vision	Covered; See brochure	Covered; See brochure
Pediatric Dental	Covered; See brochure	Covered; See brochure

Benefit Sheet

	Blue Shield Gold Tandem PPO 500/30 OffEx (Narrow Network)	
Benefit	**In Network**	**Out of Network**
Individual Ded	$500	$1,000
Family Ded	$1,000	$2,000
Individual OOP Max	$7,800 (incl ded)	$13,850 (incl ded)
Family OOP Max	$15,600 (incl ded)	$27,700 (incl ded)
Co-insurance	20%	40%
Lifetime Max	Unlimited	Unlimited
PC/Specialist	$30/$50 ded waived	40% after ded
Adult Preventive Care	No charge	Not covered
Child Preventive Care	No charge	Not covered
Pre/Postnatal Care	No charge	40% after ded
Physical Therapy	20% after ded	40% after ded
Chiropractic Care	$10 ded waived; 20 visits/cal yr	50% after ded; 20 visits/cal yr
Inpatient Hospital	20% after ded	40% after ded; $2,000 benefit max/day
Inpatient Surgery	20% after ded	40% after ded
Maternity Delivery/IP	20% after ded	40% after ded
Mental Health IP	20% after ded	40% after ded; $2,000 benefit max/day
Substance Abuse IP	20% after ded	40% after ded; $2,000 benefit max/day
Outpatient Facility	20% after ded/$150 + 20% after ded (ASC/Hospital)	40% after ded; $350 benefit max/day
Outpatient Surgery	20% after ded	40% after ded
Lab/X-Ray	L-$30 ded waived/20% after ded; X-$50/$100 ded waived (FS/Hospital)	40% after ded; $350 benefit max/day Hospital
Advanced Radiology	20% after ded/$100 + 20% after ded (FS/Hospital)	40% after ded; $350 benefit max/day Hospital
Mental Health OP	$30 ded waived	40% after ded
Substance Abuse OP	$30 ded waived	40% after ded
Emergency Room	$250 (waived if admitted) + 20% after ded	$250 (waived if admitted) + 20% after ded
Ambulance	20% after ded	20% after ded
Urgent Care	$30 ded waived	40% after ded
Rx Generic	$15/$20 ded waived	Not covered
Rx Preferred	$50/$70 after $100	Not covered
Rx Non-Preferred	$80/$110 after $100	Not covered
Rx Specialty	30% after $100; $250 max/script	Not covered
Rx Mail Order	2x retail copay	Not covered
Home Health Care	20% after ded; 100 visits/cal yr	Not covered
Skilled Nursing	20% after ded; 100 days/benefit period	20%/40% after ded (FS/Hosp); $2,000 benefit max/day Hosp; 100 days/benefit period
Infertility Treatment	Not covered	Not covered
DME	50% after ded	Not covered
Hospice Services	0% after ded	Not covered
Pediatric Vision	Covered; See brochure	Covered; See brochure
Pediatric Dental	Covered; See brochure	Covered; See brochure

Benefit Sheet

	Blue Shield Silver Tandem PPO 2300/45 OffEx (Narrow Network)	
Benefit	**In Network**	**Out of Network**
Individual Ded	$2,300	$4,600
Family Ded	$4,600	$9,200
Individual OOP Max	$7,800 (incl ded)	$13,850 (incl ded)
Family OOP Max	$15,600 (incl ded)	$27,700 (incl ded)
Co-insurance	40%	50%
Lifetime Max	Unlimited	Unlimited
PC/Specialist	$45/$70 ded waived	50% after ded
Adult Preventive Care	No charge	Not covered
Child Preventive Care	No charge	Not covered
Pre/Postnatal Care	No charge	50% after ded
Physical Therapy	40% after ded	50% after ded
Chiropractic Care	$15 ded waived; 20 visits/cal yr	50% after ded; 20 visits/cal yr
Inpatient Hospital	40% after ded	50% after ded; $2,000 benefit max/day
Inpatient Surgery	40% after ded	50% after ded
Maternity Delivery/IP	40% after ded	50% after ded
Mental Health IP	40% after ded	50% after ded; $2,000 benefit max/day
Substance Abuse IP	40% after ded	50% after ded; $2,000 benefit max/day
Outpatient Facility	40% after ded/$250 + 40% after ded (ASC/Hospital)	50% after ded; $350 benefit max/day
Outpatient Surgery	40% after ded	50% after ded
Lab/X-Ray	L-$45 ded waived/40% after ded; X-$80/$130 ded waived (FS/Hospital)	50% after ded; $350 benefit max/day Hospital
Advanced Radiology	40% after ded/$150 + 40% after ded (FS/Hospital)	50% after ded; $350 benefit max/day Hospital
Mental Health OP	$45 ded waived	50% after ded
Substance Abuse OP	$45 ded waived	50% after ded
Emergency Room	$350 (waived if admitted) + 40% after ded	$350 (waived if admitted) + 40% after ded
Ambulance	40% after ded	40% after ded
Urgent Care	$45 ded waived	50% after ded
Rx Generic	$20/$25 ded waived	Not covered
Rx Preferred	$75/$100 after $300	Not covered
Rx Non-Preferred	$115/$155 after $300	Not covered
Rx Specialty	40% after $300; $250 max/script	Not covered
Rx Mail Order	2x retail copay	Not covered
Home Health Care	40% after ded; 100 visits/cal yr	Not covered
Skilled Nursing	40% after ded; 100 days/benefit period	40%/50% after ded (FS/Hosp); $2,000 benefit max/day Hosp; 100 days/benefit period
Infertility Treatment	Not covered	Not covered
DME	50% after ded	Not covered
Hospice Services	0% after ded	Not covered
Pediatric Vision	Covered; See brochure	Covered; See brochure
Pediatric Dental	Covered; See brochure	Covered; See brochure

Group Medical Proposal

Prepared For	Effective Date	Zip (County)	Employer Contribution
Teach Inc. by Simpolicy Insurance Solutions, LLC on September 09, 2021	December 01, 2020	90047 (Los Angeles)	EE: 0% Dep: 0%

Table Rates

Zip:90047 (Los Angeles) 12/01/2020 Monthly

Age	Blue Shield Region 16 Bronze Tandem PPO Savings 5300/40% OffEx	Blue Shield Region 16 Gold Tandem PPO 1200/35 OffEx	Blue Shield Region 16 Gold Tandem PPO 500/30 OffEx	Blue Shield Region 16 Silver Tandem PPO 2300/45 OffEx
0 -14	218.16	280.54	293.18	252.64
15 -15	237.55	305.47	319.24	275.10
16 -16	244.97	315.01	329.20	283.69
17 -17	252.38	324.54	339.16	292.27
18 -18	260.37	334.81	349.89	301.52
19 -19	268.35	345.08	360.63	310.77
20 -20	276.62	355.71	371.74	320.35
21 -21	285.18	366.71	383.24	330.25
22 -22	285.18	366.71	383.24	330.25
23 -23	285.18	366.71	383.24	330.25
24 -24	285.18	366.71	383.24	330.25
25 -25	286.32	368.18	384.77	331.57
26 -26	292.02	375.51	392.43	338.18
27 -27	298.87	384.32	401.63	346.11
28 -28	309.99	398.62	416.58	358.98
29 -29	319.12	410.35	428.84	369.55
30 -30	323.68	416.22	434.97	374.84
31 -31	330.52	425.02	444.17	382.76
32 -32	337.37	433.82	453.37	390.69
33 -33	341.65	439.32	459.12	395.64
34 -34	346.21	445.19	465.25	400.93
35 -35	348.49	448.12	468.31	403.57
36 -36	350.77	451.06	471.38	406.21
37 -37	353.05	453.99	474.45	408.85
38 -38	355.33	456.93	477.51	411.50
39 -39	359.90	462.79	483.64	416.78
40 -40	364.46	468.66	489.78	422.06
41 -41	371.30	477.46	498.97	429.99
42 -42	377.86	485.90	507.79	437.59
43 -43	386.99	497.63	520.05	448.15
44 -44	398.40	512.30	535.38	461.36
45 -45	411.80	529.53	553.39	476.89
46 -46	427.77	550.07	574.85	495.38
47 -47	445.74	573.17	599.00	516.19
48 -48	466.27	599.58	626.59	539.96
49 -49	486.52	625.61	653.80	563.41
50 -50	509.33	654.95	684.46	589.83
51 -51	531.86	683.92	714.74	615.92
52 -52	556.67	715.83	748.08	644.65
53 -53	581.77	748.10	781.80	673.72
54 -54	608.86	782.93	818.21	705.09
55 -55	635.95	817.77	854.62	736.46
56 -56	665.32	855.54	894.09	770.48
57 -57	694.98	893.68	933.95	804.83
58 -58	726.64	934.39	976.49	841.48
59 -59	742.32	954.56	997.56	859.65
60 -60	773.98	995.26	1040.10	896.31
61 -61	801.35	1030.47	1076.89	928.01
62 -62	819.32	1053.57	1101.04	948.82
63 -63	841.85	1082.54	1131.31	974.91
64 -99	855.54	1100.14	1149.71	990.76

This report doesn't include rider rates in the premium.