Blue Shield PPO $200 Deductible Plan

Benefits		Blue Shield (EIAHealth) PPO MH/SA Carved Out with MHN Current			Blue Shield (EIAHealth) PPO MH/SA Carved Out with MHN Renewal		
		In-Network	Out-of-Network		In-Network	Out-of-Network	
Calendar Year Deductible Individual / Family		$200 / $400			$200 / $400		
Annual Out-of-Pocket Maximum Individual / Family		$1,000 / $2,000			$1,000 / $2,000		
Lifetime Maximum Per Person		Unlimited			Unlimited		
Physician Office Visit		20%	40%		20%	40%	
Specialist Copay		20%	40%		20%	40%	
Preventative Care		No Charge	40%		No Charge	40%	
Lab and X-Ray		20%	40%		20%	40%	
Hospitalization Inpatient		20%	40%		20%	40%	
Outpatient Surgery		20%	40%		20%	40%	
Emergency Room		$50/visit + 20% ($50 waived if admitted)	$50/visit + 20% ($50 waived if admitted)		$50/visit + 20% ($50 waived if admitted)	$50/visit + 20% ($50 waived if admitted)	
Ambulance Services		20%	20%		20%	20%	
Durable Medical Equipment		20%	40%		20%	40%	
Home Health Services		20%	Not Covered		20%	Not Covered	
Hospice Care		20%	Not Covered		20%	Not Covered	
Chiropractic		$10/visit	50% (Max $30/visit)		$10/visit	50% (Max $30/visit)	
		(30 visits/calendar year)			(30 visits/calendar year)		
Acupuncture (smoking cessation only)		20%	20%		20%	20%	
Prescription Drugs		**Medco: Generic / Brand /Non-Formulary**			**Medco: Generic / Brand /Non-Formulary**		
Retail		$10/$15/$30 (34 day)			$10/$15/$30 (34 day)		
Mail Order		$10/$15/$30 (90 day)	Not Covered		$10/$15/$30 (90 day)	Not Covered	
Rate Guarantee		**1/1/13-12/31/13**			**1/1/14-12/31/14**		
Rates		**Medical**	**MHN (MH/SA)**	**Total**	**Medical**	**MHN (MH/SA)**	**Total**
Employee Only	194	**$1,005.00**	**$6.69**	**$1,011.69**	**$1,008.00**	**$7.02**	**$1,015.02**
Two Party	194	**$1,811.00**	**$13.38**	**$1,824.38**	**$1,816.00**	**$14.05**	**$1,830.05**
Family	194	**$2,517.00**	**$19.45**	**$2,536.45**	**$2,524.00**	**$20.42**	**$2,544.42**
Monthly Premium	582	**$1,034,602**	**$7,667**	**$1,042,269**	**$1,037,512**	**$8,050**	**$1,045,562**
Annual Premium		**$12,415,224**	**$92,003**	**$12,507,227**	**$12,450,144**	**$96,603**	**$12,546,747**
$ Change to Current					**$34,920**	**$4,600**	**$39,520**
% Change to Current					**0.28%**	**5.00%**	**0.32%**

Blue Shield PPO $1,250 Account-based Health Plan

Blue Shield PPO
Effective Date: 1/1/2014

To Replace PPO 1000 Plan

Benefits	Blue Shield (EIAHealth) PPO MH/SA Carved Out with MHN Renewal			Blue Shield (EIAHealth) PPO MH/SA Carved Out with MHN ABHP Option		
	In-Network	**Out-of-Network**		**In-Network**	**Out-of-Network**	
Calendar Year Deductible Individual / Family	$200 / $400			Aggregate Deductible $1,250/$2,500		
Annual Out-of-Pocket Maximum Individual / Family	$1,000 / $2,000			$2,500 / $5,000	$5,000/ $6,000	
Lifetime Maximum Per Person	Unlimited			Unlimited		
Physician Office Visit	20%	40%		30% After Deductible	50% After Deductible	
Specialist Copay	20%	40%		30% After Deductible	50% After Deductible	
Preventative Care	No Charge	40%		No Charge	50% After Deductible	
Lab and X-Ray	20%	40%		20% After Deductible	50% After Deductible	
Hospitalization						
Inpatient	20%	40%		20% After Deductible	50% After Deductible	
Outpatient Surgery	20%	40%		20% After Deductible	50% After Deductible	
Emergency Room	$50/visit + 20% ($50 waived if admitted)	$50/visit + 20% ($50 waived if admitted)		$50 + 20% After Deductible	$50 + 20% After Deductible	
Ambulance Services	20%	20%		20% After Deductible	50% After Deductible	
Durable Medical Equipment	20%	40%		20% After Deductible	50% After Deductible	
Home Health Services	20%	Not Covered		20% After Deductible	Not Covered	
Hospice Care	20%	Not Covered		20% After Deductible	Not Covered	
Chiropractic	$10/visit	50% (Max $30/visit)		$10/visit After Deductible	50% After Deductible (Max $30/visit)	
	(30 visits/calendar year)			(30 visits/calendar year)		
Acupuncture (smoking cessation only)	20%	20%		30% After Deductible	50% After Deductible	
Prescription Drugs	**Medco: Generic / Brand /Non-Formulary**			**Medco: Generic / Brand /Non-Formulary**		
Retail	$10/$15/$30 (34 day)			$10/$15/$30 After Deductible (34 day)		
Mail Order	$10/$15/$30 (90 day)	Not Covered		$10/$15/$30 (90 day) After Deductible	Not Covered	
Rate Guarantee	**1/1/14-12/31/14**			**1/1/14-12/31/14**		
Rates	**Medical**	**MHN (MH/SA)**	**Total**	**Medical**	**MHN (MH/SA)**	**Total**
Employee Only	**$1,008.00**	**$7.02**	**$1,015.02**	**$776.00**	**$7.02**	**$783.02**
Two Party	**$1,816.00**	**$14.05**	**$1,830.05**	**$1,399.00**	**$14.05**	**$1,413.05**
Family	**$2,524.00**	**$20.42**	**$2,544.42**	**$1,944.00**	**$20.42**	**$1,964.42**
Monthly Premium	**$1,037,512**	**$8,049**	**$1,045,561**	**$799,086**	**$8,049**	**$807,135**
Annual Premium	**$12,450,144**	**$96,589**	**$12,546,733**	**$9,589,032**	**$96,589**	**$9,685,621**

Kaiser HMO

Benefits		Kaiser HMO Current					Kaiser HMO Renewal				
Annual Out-of-Pocket Maximum Individual / Family		$1,500 / $3,000					$1,500 / $3,000				
Lifetime Maximum		Unlimited					Unlimited				
Hospital All Inpatient Services		No Charge					No Charge				
Outpatient Surgery		$15/procedure					$15/procedure				
Physician & Specialist Office Visit		$15/visit					$15/visit				
Preventative Care		No Charge					No Charge				
Vision Exam (Refraction)		$15/visit					$15/visit				
Diagnostic X-Ray and Lab		No Charge					No Charge				
Ambulance Service		No Charge					No Charge				
Emergency Room (waived if admitted)		$15/visit					$15/visit				
Mental Health Inpatient		No Charge					No Charge				
Outpatient		Individual: $15/visit; Group: $7/visit					Individual: $15/visit; Group: $7/visit				
Substance Abuse Inpatient (Detox Only)		No Charge					No Charge				
Outpatient		Individual: $15/visit; Group: $5/visit					Individual: $15/visit; Group: $5/visit				
Durable Medical Equipment		No Charge					No Charge				
Hearing Aid		$2,500 Allowance per aid every 36 Months					$2,500 Allowance per aid every 36 Months				
Skilled Nursing Facility Care		No Charge (100 days/benefit period)					No Charge (100 days/benefit period)				
Speech/Physical/Occupational Therapy		$15/visit					$15/visit				
Hospice		No Charge					No Charge				
Acupuncture		Not Covered					Not Covered				
Chiropractic		$10/visit (30 visits/calendar year)					$10/visit (30 visits/calendar year)				
Vision Benefit											
Eye Exam (Refraction Only)		$15/visit					$15/visit				
Eyewear		$175 Allowance every 24 Months					$175 Allowance every 24 Months				
Prescription Drug		**Generic / Brand / Non-Formulary**					**Generic / Brand / Non-Formulary**				
Retail (100-Day Supply)		$10 / $10 / N/A					$10 / $10 / N/A				
Mail Order Program (100-Day Supply)		$10 / $10 / N/A					$10 / $10 / N/A				
Rate Guarantee		**1/1/12-1/1/13**					**1/1/13-1/1/14**				
Rates	Total	**Medical**	**Chiro**	**Vision**	**Total without Vision**	**Total with Vision**	**Medical**	**Chiro**	**Vision**	**Total without Vision**	**Total with Vision**
Employee Only	210	$640.83	$1.80	$6.14	**$642.63**	**$648.77**	$647.33	$1.80	$6.14	**$649.13**	**$655.27**
Two Party	146	$1,281.66	$3.60	$12.28	**$1,285.26**	**$1,297.54**	$1,294.65	$3.60	$12.28	**$1,298.25**	**$1,310.53**
Family	168	$1,813.55	$5.09	$17.37	**$1,818.64**	**$1,836.01**	$1,831.93	$5.09	$17.38	**$1,837.02**	**$1,854.40**
Monthly Premium	524				**$628,132**	**$634,132**				**$634,481**	**$640,483**
Annual Premium					**$7,537,581**	**$7,609,587**				**$7,613,774**	**$7,685,799**
$ Change to Current										**$76,193**	**$76,213**
% Change to Current										**1.01%**	**1.00%**

Enrollment as of 6/30/2012

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Kaiser Senior Advantage

Benefits		Kaiser HMO Current					Kaiser HMO Renewal				
Annual Out-of-Pocket Maximum											
Individual / Family		$1,500 / $3,000					$1,500 / $3,000				
Lifetime Maximum		Unlimited					Unlimited				
Hospital											
All Inpatient Services		No Charge					No Charge				
Outpatient Surgery		$5/procedure					$5/procedure				
Physician & Specialist Office Visit		$5/visit					$5/visit				
Preventative Care		No Charge					No Charge				
Vision Exam (Refraction)		$5/visit					$5/visit				
Diagnostic X-Ray and Lab		No Charge					No Charge				
Ambulance Service		No Charge					No Charge				
Emergency Room (waived if admitted)		$5/visit					$5/visit				
Mental Health											
Inpatient		No Charge					No Charge				
Outpatient		Individual: $5/visit; Group: $2/visit					Individual: $5/visit; Group: $2/visit				
Substance Abuse											
Inpatient (Detox Only)		No Charge					No Charge				
Outpatient		Individual: $5/visit; Group: $2/visit					Individual: $5/visit; Group: $2/visit				
Durable Medical Equipment		No Charge					No Charge				
Hearing Aid		$2,500 Allowance per aid every 36 Months					$2,500 Allowance per aid every 36 Months				
Skilled Nursing Facility Care		No Charge (100 days/benefit period)					No Charge (100 days/benefit period)				
Speech/Physical/Occupational Therapy		$5/visit					$5/visit				
Hospice (Members without Medicare Part A)		No Charge					No Charge				
Acupuncture		Not Covered					No Charge				
Chiropractic		$10/visit (30 visits/calendar year)					$10/visit (30 visits/calendar year)				
Vision Benefit											
Eye Exam (Refraction Only)		$5/visit					$5/visit				
Eyewear		$175 Allowance every 24 Months					$175 Allowance every 24 Months				
Prescription Drug		**Generic / Brand / Non-Formulary**					**Generic / Brand / Non-Formulary**				
Retail (100-day supply)		$10 / $10 / N/A					$10 / $10 / N/A				
Mail Order Program (100-day supply)		$10 / $10 / N/A					$10 / $10 / N/A				
Rate Guarantee		**1/1/12-1/1/13**					**1/1/13-1/1/14**				
Rates		**Medical + Vision**	**Vision**	**Chiro**	**Dental**	**Total with Dental with Vision**	**Medical + Vision**	**Vision**	**Chiro**	**Dental**	**Total with Dental with Vision**
Sub (M)	61	$390.48	$1.77	$1.80	$17.69	$409.97	$407.65	$1.83	$1.80	$18.16	$429.44
Sub (M)+Spouse (M)	11	$780.96	$3.54	$3.60	$35.38	$819.94	$815.30	$3.66	$3.60	$36.32	$858.88
Sub (M)+Spouse (Non-M)	4	$1,037.45	$7.91	$3.60	$17.69	$1,058.74	$1,054.97	$8.18	$3.60	$18.16	$1,084.91
Sub (Non-M)+Spouse (M)	7	$1,037.45	$7.91	$3.60	$17.69	$1,058.74	$1,054.98	$8.18	$3.60	$18.16	$1,084.92
Monthly Premium	83					**$45,674**					**$47,578**
Annual Premium						**$548,084**					**$570,931**
$ Change to Current											**$22,847**
% Change to Current											**4.17%**

Enrollment as of 6/30/2012

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United Healthcare HMO

Benefits	UnitedHealthcare/Pacificare HMO Current			UnitedHealthcare/Pacificare HMO Renewal				UnitedHealthcare/Pacificare HMO Alternate w/ ER Copay $125			
	In Network			In Network				In Network			
Annual Out-of-Pocket Maximum											
Individual / Family	$2,000 / $6,000			$2,000 / $6,000				$2,000 / $6,000			
Lifetime Maximum	Unlimited			Unlimited				Unlimited			
Hospital											
All Inpatient Services	No Charge			No Charge				No Charge			
Outpatient Surgery	No Charge			No Charge				No Charge			
Physician & Specialist Office Visit	$15/visit			$15/visit				$15/visit			
Preventative Care	No Charge			No Charge				No Charge			
Vision Exam (Refraction)	$15/visit			$15/visit				$15/visit			
Diagnostic X-Ray and Lab	No Charge			No Charge				No Charge			
Ambulance Service	No Charge			No Charge				No Charge			
Emergency Room (waived if admitted)	$50/visit			$50/visit				**$125/visit**			
Mental Health											
Inpatient	No Charge			No Charge				No Charge			
Outpatient	$15/visit			$15/visit				$15/visit			
Substance Abuse											
Inpatient (Detox Only)	No Charge			No Charge				No Charge			
Outpatient	No Charge			No Charge				No Charge			
Infertility	50% (Lifetime Maximum)			50% (Lifetime Maximum)				50% (Lifetime Maximum)			
Durable Medical Equipment	No Charge (Max $5,000/calendar year)			No Charge (Max $5,000/calendar year)				No Charge (Max $5,000/calendar year)			
Hearing Aid	No Charge (Max $5,000/calendar year)			No Charge (Max $5,000/calendar year)				No Charge (Max $5,000/calendar year)			
Skilled Nursing Facility Care	No Charge (100 days/calendar year)			No Charge (100 days/calendar year)				No Charge (100 days/calendar year)			
Speech/Physical/Occupational Therapy	No Charge			No Charge				No Charge			
Hospice	No Charge			No Charge				No Charge			
Acupuncture	Not Covered			Not Covered				Not Covered			
Chiropractic	Refer to additional rider			Refer to additional rider			Not Included	Refer to additional rider			Not Included
Infertility	Refer to additional rider			Refer to additional rider			Not Included	Refer to additional rider			Not Included
Vision Benefit	Please see VSP Vision Plan			Please see VSP Vision Plan				Please see VSP Vision Plan			
Prescription Drug	**Generic**	**Brand**	**Non-Formulary**	**Generic**	**Brand**	**Non-Formulary**		**Generic**	**Brand**	**Non-Formulary**	
Retail (30-day supply)	$10	$20	$25	$10	$20	$25		$10	$20	$25	
Mail Order Program (90-day supply)	$20	$40	$50	$20	$40	$50		$20	$40	$50	
Rate Guarantee	1/1/2012-1/1/2013			1/1/2013-1/1/2014				1/1/2013-1/1/2014			
Rates / **Enrollment As of 7/1/2013**	Current			Renewal			Medical without Riders	Alternate			Medical without Riders
	Medical	**Chiro**	**Combined**	**Medical**	**Chiro**	**Combined**		**Medical**	**Chiro**	**Combined**	
Employee Only 53	**$737.35**	**$3.29**	**$740.64**	**$852.49**	**$4.47**	**$856.96**	**$844.81**	**$836.00**	**$4.47**	**$840.47**	**$828.32**
Two Party 37	**$1,511.61**	**$6.58**	**$1,518.19**	**$1,747.47**	**$9.15**	**$1,756.62**	**$1,731.72**	**$1,713.68**	**$9.15**	**$1,722.83**	**$1,697.93**
Family 77	**$2,138.19**	**$9.54**	**$2,147.73**	**$2,472.08**	**$12.95**	**$2,485.03**	**$2,449.80**	**$2,424.27**	**$12.95**	**$2,437.22**	**$2,401.99**
Monthly Premium 167	**$260,802**			**$301,761**			**$297,483**	**$295,956**			**$291,678**
Annual Premium	**$3,129,626**			**$3,621,134**			**$3,569,798**	**$3,551,467**			**$3,500,131**
$ Change to Current				**$491,508**			**$440,172**	**$421,841**			**$370,505**
% Change to Current				**15.70%**			**14.06%**	**13.48%**			**11.84%**

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Delta Dental PPO

Benefits	Delta Dental (CSAC-EIA) PPO Current		Delta Dental (CSAC-EIA) PPO Renewal	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Maximum				
Per Patient per Calendar Year	$1,600	$1,500	$1,600	$1,500
Calendar Year Deductible				
Individual / Family	$50 / $150	$50 / $150	$50 / $150	$50 / $150
	(Waived for Diagnostic & Preventive)		(Waived for Diagnostic & Preventive)	
Diagnostic & Preventive				
Oral Examinations Routine Cleanings X-Rays Fluoride Treatment Space Maintainers Sealants	100%	100%	100%	100%
Basic Services				
Fillings Root Canals Periodontics (Gum Treatment) Oral Surgery/Extractions	80%	80%	80%	80%
Major Services				
Crowns & Cast Restorations Inlays / Onlays	60%	60%	60%	60%
Prosthodontics				
Bridges Partial / Full Dentures Implants	60%	60%	60%	60%
Orthodontics				
Adult & Child Orthodontics	None		None	
Dental Accident Benefits				
Maximum	None		None	
Coverage	100% (Must be treated within 90 Days of Accident)		100% (Must be treated within 90 Days of Accident)	

Rate Guarantee		**12-Month (7/1/12-6/30/13)**	**12-Month (7/1/13-6/30/14)**
Monthly ASO Fee		**7.5% of projected claims PEPM**	**7.5% of projected claims PEPM**
Program Management Fee PEPM	1,152	**$0.85**	**$0.85**
Monthly ASO Fee		**$979**	**$979**

Recommended Funding Rates (include ASO Fee)		Renewal (1/1/13-12/31/13)	Renewal (1/1/14-12/31/14)	Change Dependent Eligibility to Voluntary
Employee Only	374	**$54.28**	**$55.69**	63.37
Two Party	348	**$97.71**	**$100.24**	114.07
Family	430	**$135.71**	**$139.22**	158.43
Monthly Premium	1,152	**$112,659**	**$115,577**	**$131,522**
Annual Premium		**$1,351,909**	**$1,386,924**	**$1,578,260**
$ Change to Current			**$35,014**	**$226,350**
% Change to Current			**2.6%**	**16.7%**

Enrollment as of 7/1/2013

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VSP Vision

Benefits		VSP Signature Current		VSP Signature Renewal		VSP Choice Option	
		In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Eligibility		All Active Employees on Blue Shield and UnitedHealthcare plans		All Active Employees on Blue Shield and UnitedHealthcare plans		All Active Employees on Blue Shield and UnitedHealthcare plans	
		Copay		**Copay**		**Copay**	
Exam		$25		$25		$25	
Prescription Glasses							
Diabetic EyeCare Plus		$20 per visit		$20 per visit		$20 per visit	
		Coverage	**Pays Up To**	**Coverage**	**Pays Up To**	**Coverage**	**Pays Up To**
Exam		Covered in Full	$50	Covered in Full	$50	Covered in Full	**$45**
Frames		$115 Allowance (20% off over allowed amount)	$70	$115 Allowance (20% off over allowed amount)	$70	$115 Allowance (20% off over allowed amount)	$70
Lenses							
Single Lenses		Covered in Full	$50	Covered in Full	$50	Covered in Full	**$30**
Bifocal Lenses		Covered in Full	$75	Covered in Full	$75	Covered in Full	**$50**
Trifocal Lenses		Covered in Full	$100	Covered in Full	$100	Covered in Full	**$65**
Lenticular Lenses		Covered in Full	$125	Covered in Full	$125	Covered in Full	**$100**
Contact Lenses							
Elective		$105 Allowance (15% off contact lens services)	$105	$105 Allowance (15% off contact lens services)	$105	$105 Allowance (15% off contact lens services)	$105
Medically Necessary		Covered in Full	$210	Covered in Full	$210	Covered in Full	$210
Frequency							
Exam		12 Months		12 Months		12 Months	
Lenses		24 Months		24 Months		24 Months	
Frames		24 Months		24 Months		24 Months	
Contact Lenses *		24 Months		24 Months		24 Months	

Rate Guarantee		**36-Months (1/1/13-1/1/16)**	**36-Months (1/1/13-1/1/16)**	**36-Months (1/1/14-1/1/17)**
Monthly ASO Fee & Claims				
Administration Fee (PEPM)	728	**$1.54**	**$1.54**	**$1.24**

Recommended Funding Rates (include ASO Fee)		**12-Month (1/1/13-12/31/13)**	**12-Month (1/1/14-12/31/14)**		**12-Month (1/1/14-12/31/14)**	
			Renewal	**Change Dependent Eligibility to Voluntary**	**Renewal**	**Change Dependent Eligibility to Voluntary**
Employee Only	232	**$6.84**	**$7.22**	**$8.08**	**$5.28**	**$6.19**
Two Party	226	**$13.66**	**$14.44**	**$16.37**	**$10.56**	**$12.25**
Family	270	**$22.00**	**$23.25**	**$26.51**	**$17.00**	**$19.66**
Monthly Premium	728	**$10,612**	**$11,216**	**$12,731**	**$8,200**	**$9,513**
Annual Premium		**$127,350**	**$134,596**	**$152,767**	**$98,404**	**$114,160**
$ Change to Current			**$7,246**	**$25,418**	**($28,946)**	**($13,189)**
% Change to Current			**5.69%**	**19.96%**	**-22.73%**	**-10.36%**

* Contact lenses are in lieu of spectacle lenses and frame.

Enrollment as of 7/1/2013

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