Blue Shield PPO \$200 Deductible Plan

Benefits		MH/SA Carved	IAHealth) PPO I Out with MHN rent		Blue Shield (El MH/SA Carved Rene	Out with MHN	
		In-Network	Out-of-Network	-	In-Network	Out-of-Network	-
Calendar Year Deductible							
Individual / Family		\$200	/ \$400		\$200 /	\$400	
Annual Out-of-Pocket Maximum				-			1
Individual / Family		\$1,000	/ \$2,000		\$1,000 /	\$2,000	
Lifetime Maximum				-			1
Per Person		Unlir	nited		Unlim	ited	
Physician Office Visit	-	20%	40%		20%	40%	
Specialist Copay		20%	40%	-	20%	40%	1
Preventative Care		No Charge	40%	1	No Charge	40%	1
Lab and X-Ray		20%	40%		20%	40%	
Hospitalization							1
		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%	1
Durable Medical Equipment		20%	40%		20%	40%	1
Home Health Services		20%	Not Covered		20%	Not Covered	1
Hospice Care		20%	Not Covered		20%	Not Covered	1
Chiropractic		\$10/visit	50% (Max \$30/visit)		\$10/visit	50% (Max \$30/visit)]
	_		llendar year)	-	(30 visits/cal		-
Acupuncture (smoking cessation only)		20%	20%		20%	20%	
Prescription Drugs		Meo Generic / Brand	dco: /Non-Formulary		Medco: Generic / Brand /Non-Formulary		
Retail		\$10/\$15/\$3	30 (34 day)		\$10/\$15/\$3	0 (34 day)	
Mail Order		\$10/\$15/\$30 (90 day)	Not Covered		\$10/\$15/\$30 (90 day)	Not Covered	
Rate Guarantee			12/31/13		1/1/14-12		
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	<u>194</u>	\$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

rfectiv	e Da	te: 1/	1/201	4

		Encouve Date. 1		To Replace PP	O 1000 Plan	
Benefits	MH/SA Carve	EIAHealth) PPO d Out with MHN newal	Blue Shield (ElAHealth) PPO MH/SA Carved Out with MHN ABHP Option			
	In-Network	Out-of-Network		In-Network	Out-of-Network	
Calendar Year Deductible	\$200) / \$400		Aggregate D		
Individual / Family	· · · · · · · · · · · · · · · · · · ·			\$1,250/\$	2,500	
Annual Out-of-Pocket Maximum Individual / Family	\$1,000	/ \$2,000		\$2,500 / \$5,000	\$5,000/ \$6,000	
Per Person	Unli	imited		Unlimi	ted	
Physician Office Visit	20%	40%		30% After Deductible	50% After Deductible	
Specialist Copay	20%	40%	4	30% After Deductible	50% After Deductible	
Preventative Care	No Charge	40%	4	No Charge	50% After Deductible	
Lab and X-Ray	20%	40%	ł	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)	
		alendar year)		(30 visits/cale		
Acupuncture (smoking cessation only)	20%	20%		30% After Deductible	50% After Deductible	
Prescription Drugs	-	edco: d /Non-Formulary		Medo Generic / Brand /I		
Retail	\$10/\$15/\$	630 (34 day)		\$10/\$15/\$30 After D	eductible (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-	1/1/14-12/31/14		1/1/14-12	/31/14	
Rates	Medical	MHN (MH/SA)	Total	Medical	MHN (MH/SA)	
Employee Only	\$1,008.00	\$7.02	\$1,015.02	\$776.00	\$7.02	
Two Party	\$1,816.00	\$14.05	\$1,830.05	\$1,399.00	\$14.05	
Family	\$2,524.00	\$20.42	\$2,544.42	\$1,944.00	\$20.42	
Monthly Premium	\$1,037,512	\$8,049	\$1,045,561	\$799,086	\$8,049	
Annual Premium	\$12,450,144	\$96,589	\$12,546,733	\$9,589,032	\$96,589	

> Total \$783.02 \$1,413.05 \$1,964.42 \$807,135 \$9,685,621

Kaiser HMO

Benefits		Kaiser HMO Current					Kaiser HMO Renewal					
		Current								Kenewai		
Annual Out-of-Pocket Maximum	t i											
Individual / Family				\$1	500 / \$3,000		\$1,500 / \$3,000					
Lifetime Maximum	1				Unlimited				φ.	Unlimited		
	1											
Hospital	i i											
All Inpatient Services				Ν	lo Charge					No Charge		
Outpatient Surgery	1			\$1	5/procedure				\$	15/procedure		
	1											
Physician & Specialist Office Visit					\$15/visit					\$15/visit		
Preventative Care	ļ				lo Charge					No Charge		
Vision Exam (Refraction)	ļ				\$15/visit					\$15/visit		
Diagnostic X-Ray and Lab					lo Charge					No Charge		
Ambulance Service	ł			١	lo Charge					No Charge		
Emergency Room (waived if admitted)					\$15/visit					\$15/visit		
Mental Health												
Inpatient				Ν	lo Charge		No Charge					
Outpatient			Ind		5/visit; Group: \$7/vis	sit		In	dividual: \$	\$15/visit; Group: \$7/v	isit	
Substance Abuse	1											
Inpatient (Detox Only)				Ν	lo Charge		No Charge					
Outpatient			Ind	ividual: \$1	5/visit; Group: \$5/vis	sit	Individual: \$15/visit; Group: \$5/visit					
							Ni Olarua					
Durable Medical Equipment	-				lo Charge		No Charge					
Hearing Aid	ļ				e per aid every 36 M		\$2,500 Allowance per aid every 36 Months					
Skilled Nursing Facility Care	-		NO		00 days/benefit perio	od)	No Charge (100 days/benefit period)					
Speech/Physical/Occupational Therapy	ł				\$15/visit		\$15/visit					
Hospice	-				lo Charge ot Covered		No Charge					
Acupuncture	4		.			\ \	Not Covered \$10/visit (30 visits/calendar year)					
Chiropractic Vision Benefit			\$	10/VISIt (30	visits/calendar year)		\$	STU/VISIT (3	so visits/calendar yea	ir)	
Eye Exam (Refraction Only)	-				\$15/visit					\$15/visit		
Evewear	-		¢1		nce every 24 Months			¢	175 Allow	ance every 24 Month		
Prescription Drug	-				and / Non-Formula					Brand / Non-Formula		
Retail (100-Day Supply)	-	-	Ge		0 / \$10 / N/A	y	-	G		10 / \$10 / N/A	ary	
Mail Order Program (100-Day Supply)	-									10 / \$10 / N/A		
Rate Guarantee			\$10 / \$10 / N/A 1/1/12-1/1/13							1/1/13-1/1/14		
	1		Total Total				<u> </u>		Total	Total		
Rates	<u>Total</u>	Medical	Medical Chiro Vision without Vision with Vision				Medical	Chiro	Vision	without Vision	with Vision	
Employee Only	210	\$640.83	\$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					\$1,294.65			\$1,298.25	\$1,310.53	
Family	168	\$1,813.55				\$1,831.93		\$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	1									\$76,193	\$76,213	
% Change to Current	1									1.01%	1.00%	

Enrollment as of 6/30/2012

Note: This summary is for informational purpose only. It does not amend, extend, or alter the current policy in any way. In the event information in this summary differs from the Plan Document, the Plan Document will prevail. Please contact the Human Resources office for more information on your plans.

Kaiser Senior Advantage

Benefits Kaiser HMO Current									
Annual Out-of-Pocket Maximum Individual / Family		\$1,500 / \$3,000							
Lifetime Maximum			Unlin						
Hospital									
All Inpatient Services Outpatient Surgery			No Ch \$5/proc						
Physician & Specialist Office Visit			\$5/\	visit					
Preventative Care			No Ch	0					
Vision Exam (Refraction)			\$5/v						
Diagnostic X-Ray and Lab			No Ch	0					
Ambulance Service			No Ch						
Emergency Room (waived if admitted)			\$5/\	lsit					
Mental Health									
Inpatient			No Ch	arde					
Outpatient		Individu	al: \$5/visi		: \$2/visit				
Substance Abuse				/ 1					
Inpatient (Detox Only)			No Ch	narge					
Outpatient		Individu	ual: \$5/visi	t; Group	: \$2/visit				
Durable Medical Equipment			No Ch						
Hearing Aid		\$2,500 Allov							
Skilled Nursing Facility Care		No Char	ge (100 da		efit period)			
Speech/Physical/Occupational Therapy			\$5/\						
Hospice (Members without Medicare Part A)			No Ch						
Acupuncture		.	Not Co						
Chiropractic Vision Benefit		\$10/VIS	it (30 visit	s/calenc	ar year)				
Eye Exam (Refraction Only)			\$5/\	ligit					
Eyewear		\$175 A	۵۵/۷ llowance e		Monthe				
Prescription Drug			: / Brand /						
Retail (100-day supply)		Contract	\$10/\$1		Jimaiaiy				
Mail Order Program (100-day supply)			\$10/\$1						
Rate Guarantee			1/1/12-						
						Total			
Rates		Medical + Vision	Vision	Chiro	Dental	with Dental with Vision			
Sub (M)	61	\$390.48	\$1.77	\$1.80	\$17.69	\$409.97			
Sub (M)+Spouse (M)	11	\$780.96	\$3.54	\$3.60	\$35.38	\$819.94			
Sub (M)+Spouse (Non-M)	4	4 \$1,037.45 \$7.91 \$3.60 \$17.69 \$1,058.74							
Sub (Non-M)+Spouse (M)	7	\$1,037.45	\$7.91	\$3.60	\$17.69	\$1,058.74			
Monthly Premium	83					\$45,674			
Annual Premium						\$548,084			
\$ Change to Current									
% Change to Current									

	Kaiser Rene								
	/ 1,500 <u>(</u> Unlim								
	Unlim	ited							
	No Ch \$5/proc								
	\$3/pi00	euure							
	\$5/v	isit							
	No Ch	arge							
	\$5/v								
	No Ch								
	<u>No Ch</u> \$5/v								
	φ3/V	ISIL							
	No Ch	arge							
Individ	ual: \$5/visit		\$2/visit						
		, 0.04p.	φ <u></u> 2, ποιτ						
	No Ch	arge							
Individ	ual: \$5/visit	; Group:	\$2/visit						
	No Ch	orgo							
\$2,500 Allo			v 36 Mon	the					
	rge (100 da								
110 0114	\$5/v		n ponou)						
	No Ch	arge							
	No Ch								
\$10/vi	sit (30 visite	s/calenda	ar year)						
	\$5/v	icit							
\$175 A	۵۵/۷ Allowance e		Months						
Generi	c / Brand /	Non-Fo	rmulary						
	\$10 / \$1	0 / N/A							
	\$10/\$1								
	1/1/13-	1/1/14							
	Vision	01.1	Dental	Total					
Medical + Vision	Vision	Chiro	Dental	with Dent with Visio					
\$407.65	¢1.00	¢1.90	\$18.16	\$429.44					
\$407.65 \$815.30	\$1.83 \$3.66	\$1.80 \$3.60	\$36.32	\$429.44					
\$1,054.97	\$8.18	\$3.60	\$18.16	\$1,084.9					
\$1,054.98	\$8.18	\$3.60	\$18.16	\$1,084.9					
				\$47,578					
				\$570,93					
				\$22,847					
				4.17%					

Enrollment as of 6/30/2012

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United Healthcare HMO

Benefits		Unite	dHealthcare/Pacific	are HMO	UnitedHealthcare/Pacificare HMO			UnitedHealthcare/Pacificare HMO				
Denents			Current			R	enewal		Alternate w/ ER Copay \$125			
			In Network			In Network				In Network		
Annual Out-of-Pocket Max	ximum											
Individual / Family			\$2,000 / \$6,000			\$2,000 / \$6,000				\$2,000 / \$6,000		
Lifetime Maximum			Unlimited		Unlimited		1	Unlimited				
								1				
Hospital												
All Inpatient Services			No Charge			No Charge				No Charge		
Outpatient Surgery			No Charge			No Charge		1		No Charge		í –
			0			U				, i i i i i i i i i i i i i i i i i i i		
Physician & Specialist Office	e Visit		\$15/visit			\$15/visit		1		\$15/visit		
Preventative Care			No Charge			No Charge		1		No Charge		1
Vision Exam (Refraction)			\$15/visit			\$15/visit		1		\$15/visit		1
Diagnostic X-Ray and Lab			No Charge			No Charge		1		No Charge		
Ambulance Service			No Charge			No Charge				No Charge		1
Emergency Room (waived in	if admitted)		\$50/visit			\$50/visit		1		\$125/visit		1
	'					·		1				
Mental Health								1				
Inpatient			No Charge			No Charge						
Outpatient			\$15/visit			\$15/visit			No Charge \$15/visit			
Substance Abuse			••••			* • • • • • • • •		1	ý to tok			
Inpatient (Detox Only)			No Charge		No Charge			No Charge				
Outpatient			No Charge			No Charge		1	No Charge			1
								1	i no ondigo			
Infertility			50% (Lifetime Maxim	ium)		50% (Lifetime Maxir	num)	1	5	i0% (Lifetime Maxim	um)	
Durable Medical Equipment			arge (Max \$5,000/cal			rge (Max \$5,000/ca		1		No Charge (Max \$5,000/calendar year)		
Hearing Aid			arge (Max \$5,000/cal			rge (Max \$5,000/ca		1		ge (Max \$5,000/cale		
Skilled Nursing Facility Care	9		harge (100 days/caler			arge (100 days/cale		1		arge (100 days/calen		
Speech/Physical/Occupation			No Charge	iaar joarj		No Charge	nddi youry	1	110 0110	No Charge	aar joarj	
Hospice	nai morapy		No Charge			No Charge		1		No Charge		-
Acupuncture			Not Covered			Not Covered		1		Not Covered		-
Chiropractic			Refer to additional ri	der		Refer to additional r	ider	Not Included		Refer to additional rid	hor	Not Included
Infertility			Refer to additional ri			Refer to additional r		Not Included		Refer to additional rid		Not Included
Intertuity				uei			luei					
Vision Benefit		P	lease see VSP Visior	Plan	P	lease see VSP Visio	n Plan	-	Die	ease see VSP Vision	Plan	
Prescription Drug		Generic	Brand	Non-Formulary	Generic	Brand	Non-Formulary	1	Generic	Brand	Non-Formulary	
Retail (30-day supply)		\$10	\$20	\$25	\$10	\$20	\$25	+	\$10	\$20	\$25	
Mail Order Program (90-day		\$20	\$20	\$50	\$20	\$40	\$50	- ↓	\$20	\$40	\$50	+ ↓
Rate Guarantee	y supply)	ψ20	1/1/2012-1/1/2013		ψ20	1/1/2013-1/1/201		1	ψ20	1/1/2013-1/1/2014		
	Enrollment		Current	,		Renewal	•	Medical without	Alternate		Medical without	
Rates	As of 7/1/2013	Medical	Chiro	Combined	Medical	Chiro	Combined	Riders	Medical	Chiro	Combined	Riders
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	\$1,511.61	\$9.58 \$9.54	\$1,518.19 \$2,147.73	\$1,747.47	\$9.15 \$12.95	\$1,756.62	\$1,731.72 \$2,449.80	\$1,713.08	\$9.15 \$12.95	\$1,722.83 \$2,437.22	\$1,697.93
Family Monthly Premium	167	φ <u>∠</u> ,138.19	\$9.54	φ2,141.13	\$ <u>2,472.08</u>	\$12.95	⊅ ∠,480.03	\$2,449.80	φ ∠ ,424.21	\$12.95	φz,431.22	\$2,401.99
	10/		\$200,802 \$3,129,626							. ,		
Annual Premium	-		\$3,129,020			\$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			CSAC-EIA) PPO rrent		(CSAC-EIA) PPO enewal	
		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				· · · · · · · · · · · · · · · · · · ·	•••	
ndividual / Family	1	\$ <u>50 / \$150</u> (Waived for Diag	<u>\$50 / \$150</u> nostic & Preventive)	<u>\$50 / \$15</u> 0 (Waived for Diac	\$50 / \$150	
Diagnostic & Preventive		(Trained for Diag		(Traired for Diag		
Dral Examinations	7					
Routine Cleanings						
K-Rays						
Fluoride Treatment		100%	100%	100%	100%	
Space Maintainers						
Sealants						
Basic Services						
Fillings	7					
Root Canals						
Periodontics (Gum Treatment)		80%	80%	80%	80%	
Dral Surgery/Extractions						
Major Services						
Crowns & Cast Restorations	-					
nlays / Onlays		60%	60%	60%	60%	
Prosthodontics						
Bridges	-					
Partial / Full Dentures		60%	60%	60%	60%	
mplants						
Orthodontics			•			
Adult & Child Orthodontics	7	N	lone	1	None	
Dental Accident Benefits						
Vlaximum	7	N	one	1	None	
Coverage			within 90 Days of Accident)		within 90 Days of Accident)	
20101290		10070 (11401 20 1104104				1
Rate Guarantee		12-Month (7	7/1/12-6/30/13)	12-Month (7/1/13-6/30/14)	
Monthly ASO Fee		7.5% of projec	ted claims PEPM	7.5% of project	cted claims PEPM	1
Program Management Fee PEPM	1,152	\$0).85	\$	0.85	
Monthly ASO Fee		\$	979		\$979	
	-					1
Recommended Funding Rates						
(include ASO Fee)		Renewal (1/	1/13-12/31/13)	Renewal (1	/1/14-12/31/14)	Change Dependent Eligibility to Vo
· · · · · ·			-	-	-	
Employee Only	374		4.28	-	55.69	63.37
Two Party	348		7.71	-	00.24	114.07
Family	430	\$13	35.71		39.22	158.43
Monthly Premium	1,152	\$11	2,659	\$11	15,577	\$131,522
Annual Premium		\$1,3	51,909	\$1,3	86,924	\$1,578,260
\$ Change to Current				\$3	5,014	\$226,350
0/ Channe to Cument					0.00/	40 70/

% Change to Current Enrollment as of 7/1/2013

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16.7%

2.6%

VSP Vision

Benefits		VSP Sig			P Signature	VSP Choice Option		
		Curr In-Network	Non-Network		Renewal Non-Network	In-Network		
Eligibility		All Active En Blue Shield and Unit	nployees on edHealthcare plans		ve Employees on I UnitedHealthcare plans	All Active Employees on Blue Shield and UnitedHealthcare plans		
		Cor	bay		Сорау	Сорау		
Exam Prescription Glasses		\$2	25		\$25	\$	25	
Diabetic EyeCare Plus		\$20 pe	ar vicit		20 per visit	\$20 r	er visit	
Diabetic Lyeoare rids		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 M	onths		12 Months	12 N	lonths	
Lenses		24 M	onths		24 Months	24 Months		
Frames		24 M	onths		24 Months	24 Months		
Contact Lenses *		24 M	onths		24 Months	24 Months		
Rate Guarantee		36-Months (1	14 14 2 4 14 14 6	26 Mant	hs (1/1/13-1/1/16)	26 Montho (1/1/14-1/1/17)	
Monthly ASO Fee & Claims		30-WORLIS (1	/ 1/ 13- 1/ 1/ 10)	36-MOIIL		30-1011115 (1/1/14-1/1/1/	
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	n (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		\$14.44	\$16.37	\$10.56	\$12.25	
Family	270	\$22		\$23.25	\$26.51	\$17.00	\$19.66	
Monthly Premium	728	\$10,		\$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

Note: This summary is for informational purpose only. It does not amend, extend, or alter the current policy in any way. In the event information in this summary differs from the Plan Document, the Plan Document will prevail. Please contact the Human Resources office for more information on your plans.