

EXHIBIT A

Kent County Water Board Meeting

May 19, 2011

Employee Benefits

Insurance Renewal

For

Kent County Water Authority

July 1, 2011

Presented by:

Kimberly A. Muldoon, APR, CLTC

Account Executive, Employee Benefits

Starkweather & Shepley Insurance Brokerage, Inc.

May 19, 2011

DISCLAIMER: This proposal or summary is provided for illustration purposes only; it is not a legal contract and is based on information provided by the client/prospect. It is provided to facilitate your understanding of your insurance program. Please refer to the actual policies for specific terms, conditions, limitations, and exclusions that will govern in the event of a loss.



A. M. BEST FINANCIAL RATINGS

<u>COMPANY</u>	<u>RATING</u>	<u>FINANCIAL SIZE CATEGORY</u>
BLUE CROSS BLUE SHIELD OF RI	NOT FORMALLY FOLLOWED	(NR-5)
TUFTS HEALTH PLAN	NOT FORMALLY FOLLOWED	(NR-5)
UNITED HEALTHCARE	A	
BLUE CROSS DENTAL	NOT FORMALLY FOLLOWED	(NR-5)
DELTA DENTAL OF RI	NOT FORMALLY FOLLOWED	(NR-5)
UNITED HEALTHCARE DENTAL	A	
MUTUAL OF OMAHA	A+	

The financial strength and security of the insurance companies that underwrite your business is of paramount importance. With this in mind, you will note that we have provided the A.M. Best's rating of the insurance company in your insurance proposal. For more information on this important topic, we suggest that you visit their website at www.ambest.com.



Starkweather & Shepley Insurance Brokerage, Inc.
Telephone (401) 435-3600 Toll Free (800) 854-4625

The following are your direct contacts with our agency:

Kimberly Muldoon - APR, CLTC - Account Executive **Ext. 1251**

Provides complete and full service as your personal agent for any of your insurance needs.

Email: kmuldoon@starshep.com Direct Fax: (401) 431-9667

Lynn Barbosa - Account Manager **Ext. 1382**

An assistant to Kim, Lynn will provide any of your insurance needs.

Email: lbarbosa@starshep.com Direct Fax: (401) 431-9675

Donna Mercurio - Account Manager **Ext. 1248**

In the absence of Kim or Lynn, Donna is available to service any of your insurance needs.

Email: dmercurio@starshep.com Direct Fax: (401) 431-9669



Rhode Island Small Employer Health Insurance Renewal Explanation Form

Insurer Name: **Blue Cross and Blue Shield of Rhode Island** Group Name: **KENT COUNTY WATER AUTHORITY**
 Renewal Date: **07/01/2011 to 06/30/2012** Group Number: **269**

Factors that Changed Your Rate:

Note: In accordance with RI law, the rate change for your small employer plan can only be based on the following factors:

	V10080	
A. Change in Community Base Rate:	4.1%	
B. Change in Age, Gender	-0.9%	
C. Elimination of Health Status Factor	0.0%	
D. Impact of 4:1 Rate Cap	0.0%	
E. Change in Riders	0.0%	
F. Total Change in Premium per Subscriber	3.1%	
Overall Change in Total Premium		3.1%

Broker/Agent: **Starkweather & Shepley Inc**

Note: Broker payments are included in premiums for all small employers. Broker payments average 2.7% of total small employer premiums. ⁶

Explanations:

- A. This change covers the insurer's cost for all small employers. It is based on components approved annually by the Health Insurance Commissioner, is included in all small employer rates for this period, and is not specific to your group.
- B. This change is a result of any changes in the age or gender of enrolled employees within your specific group.
- C. In accordance with RI law, effective January 1, 2009, insurers may no longer adjust small employer rates based on health status of the employer. The change reflected in this line results from the elimination of health status as a rating factor to bring your group to the community rate.
- D. By law, no rate for any small employer in a set time period can be more than four times the lowest rate for any other small employer, for the same plan of benefits. The resulting change (if any) is listed here.
- E. Riders are benefits that are purchased separately, such as acupuncture, vision or dental.
- F. The total change in premium per subscriber is the combined effect of any changes in A through E above. The final cost increase to your group will be based on the above change in premium, and your enrollment by family type as shown below.
- G. Insurance brokers/agents assist and advise small employers in the selection of health insurance policies and provide account servicing. Brokers/agents are not employees of any particular health insurance carrier, but may receive commissions from health insurance carriers. In accordance with RI law, these payments are charged evenly across all small employers, and are included in the base rate. The decision to utilize the services of a broker/agent will not affect the amount of your premium.

Family Composition Factors Used to Develop Total Premiums

Changes in Family Composition may affect your overall premium. The pricing relationships used in developing your renewal rates are as follows:

Pricing Relationship	Individual	Individual/Spouse	Individual/Child(ren)	Family
	1.0	2.4	1.6	2.7

Enrollment Used to Develop Total Premiums

Changes in Family Composition may affect your overall premium. Here is the enrollment used to develop your health plan renewal rates:

Pricing Relationship	Individual	Individual/Spouse	Individual/Child(ren)	Family
V10080	2	8	4	18

Questions? Call the broker listed above, or Celina A. Krupski at Blue Cross and Blue Shield of Rhode Island at 1-800-637-3718.



This form was designed on behalf of small employers by the Office of the Health Insurance Commissioner (OHIC) pursuant to RI Gen Law 27-50-12.1. For more information, please contact OHIC at (401) 462-9517; or visit www.ohic.ri.gov/renewalexplanationform.php

Kent County Water Authority
Financial Analysis
 Rates Effective July 01, 2011 - June 30, 2012

CARRIER:			Single 4 Contracts	Emp. & Sp. 5 Contracts	Emp. & Ch. 4 Contracts	Family 19 Contracts	Estimated Annualized Premium	% Renewal Increase (Decrease)	\$ Renewal Increase (Decrease)
Company Sponsored	Blue Cross Blue Shield								
	HMC2C 15/25 (R1)	Current Rates	\$549.11	\$1,317.87	\$878.58	\$1,482.60	\$485,634	N/A	N/A
	\$15 / \$25 Office Visit, \$100 Emergency Room, \$7, \$30, \$50, \$75 Rx. 100% Hospital	Current Enrollment	4	5	4	19			
Company Sponsored Plan	VantageBlue 100/80 \$250 Ded New Rx								
	\$15 / \$25 Office Visit, \$100 Emergency Room, \$10, \$35, \$60, \$100 Rx., \$250 / \$500 Deductible. Hybrid	Renewal Rates	\$566.11	\$1,358.65	\$905.76	\$1,528.48	\$500,662	3.1%	\$15,028
	Deductible applies to: 100% In Patient / Out Patient Hospital, Diagnostic Lab & X-rays, 80% Physical / Speech / Occupational Therapy & DME.	Current Enrollment	4	5	4	19			

Kent County Water Authority
Financial Analysis
Rates Effective July 01, 2011 - June 30, 2012

		Single 4	Emp. & Sp. 5	Emp. & Ch. 4	Family 19	Estimated Annualized Premium	% Renewal Increase (Decrease)	\$ Renewal Increase (Decrease)
CARRIER:		Contracts	Contracts	Contracts	Contracts			
	Blue Cross Blue Shield							
Option Number								
1	VantageBlue 100/80 \$500 Ded New Rx \$15 / \$25 Office Visit, \$100 Emergency Room, \$10, \$35, \$60, \$100 Rx., \$500 / \$1,000 Deductible. Hybrid Deductible applies to: 100% In Patient / Out Patient Hospital, Diagnostic Lab & X-rays, 80% Physical / Speech / Occupational Therapy & DME.	\$532.02	\$1,276.85	\$851.23	\$1,436.46	\$470,520	-3.1%	(\$15,114)
2	VantageBlue 100/80 \$1,000 Ded New Rx \$15 / \$30 Office Visit, \$100 Emergency Room, \$10, \$35, \$60, \$100 Rx. \$1,000 / \$2,000 Deductible. Hybrid Deductible applies to: 100% In Patient / Out Patient Hospital, Diagnostic Lab & X-rays, 80% Physical / Speech / Occupational Therapy & DME.	\$483.85	\$1,161.24	\$774.15	\$1,306.39	\$427,915	-11.9%	(\$57,719)
3	\$2,000 / \$4,000 Ded Preventative Care Service (annual exams, well child visits, immunizations, PAP smears, screening mammograms and PSA tests) covered at 100% \$2,000 / \$4,000 Family Deductible, For all other services excluding prescriptions, Rx \$10, \$35, \$60, \$100. Coverage for all services is 100% after Deductible is met.	\$413.66	\$992.78	\$661.85	\$1,116.87	\$365,838	-24.7%	(\$119,796)
4	BlueSolutions for HSA 100/60 (\$1,500/\$3,000) Preventative Care Service (annual exams, well child visits, immunizations, PAP smears, screening mammograms and PSA tests) covered at 100% \$1,500 / \$3,000 Family Deductible, For all other services including prescriptions, \$10/\$35/\$60/\$100 Rx Coverage for all services is 100% after Deductible is met.	\$446.92	\$1,072.60	\$715.07	\$1,206.68	\$395,255	-18.6%	(\$90,380)

Kent County Water Authority
Financial Analysis
Rates Effective July 01, 2011 - June 30, 2012

CARRIER:		Single 4	Emp. & Sp. 5	Emp. & Ch. 4	Family 19	Estimated Annualized Premium	% Renewal Increase (Decrease)	\$ Renewal Increase (Decrease)
Option Number		Contracts	Contracts	Contracts	Contracts			
	United Healthcare							
5	U8T (H9) \$10 Office Visit, \$100 Emergency Room, \$10, \$30, \$50 Rx No Deductible, 100% Coverage	\$586.96	\$1,261.96	\$1,203.27	\$1,614.12	\$529,668	9.1%	\$44,034
6	U8V (H9) \$20 / \$30 Office Visit, \$125 Emergency Room, \$10, \$30, \$50 Rx No Deductible, 100% Coverage	\$545.64	\$1,173.13	\$1,118.57	\$1,500.50	\$492,384	1.4%	\$6,750
7	U8U (H9) \$15 Office Visit, \$100 Emergency Room, \$10, \$30, \$50 Rx \$300 / \$600 Ded, 100% Coverage Deductible applies to: Inpatient / Outpatient Hospital Services, MRIs, MRAs, Pet Scans, Cat Scans, Nuclear Testing and DME	\$543.27	\$1,168.03	\$1,113.71	\$1,493.98	\$490,244	0.9%	\$4,610
8	U8W (H9) \$20 Office Visit, \$100 Emergency Room, \$10, \$30, \$50 Rx \$500 / \$1,000 Ded, 100% Coverage Deductible applies to: Inpatient / Outpatient Hospital Services, MRIs, MRAs, Pet Scans, Cat Scans, Nuclear Testing and DME	\$516.81	\$1,111.14	\$1,059.46	\$1,421.21	\$466,365	-4.0%	(\$19,269)
9	1RB (H9) \$10, \$30, \$50 Rx \$2,000 / \$4,000 Ded, 100% Coverage Deductible applies to all services except preventive care	\$393.32	\$845.64	\$806.31	\$1,081.63	\$354,932	-26.9%	(\$130,702)
10	HSA - U1G (H9) No Co-payment for annual preventive exam & related tests \$1,500 / \$3,000 Deductible for all other services including prescriptions 100% Coverage \$10, \$30, \$50 Rx after the deductible	\$396.04	\$851.49	\$811.88	\$1,089.10	\$357,384	-26.4%	(\$128,250)

Kent County Water Authority
Financial Analysis
Rates Effective July 01, 2011 - June 30, 2012

		Single 4	Emp. & Sp. 5	Emp. & Ch. 4	Family 19	Estimated Annualized Premium	% Renewal Increase (Decrease)	\$ Renewal Increase (Decrease)
CARRIER:		Contracts	Contracts	Contracts	Contracts			
	Tufts							
Option Number								
11	PPO Choice 15/25 \$15/\$25 Office Visit, \$100 Emergency Room, \$10, \$25, \$45 Rx. 100% Hospital.	\$644.66	\$1,547.18	\$1,031.46	\$1,740.58	\$570,137	17.4%	\$84,503
12	Advantage PPO 250 (100/80) \$15 / \$25 Office Visit, \$100 Emergency Room, \$10, \$30, \$45 Rx. \$250 / \$500 Deductible, 100% Deductible applies to: In Patient / Out Patient, Spinal Manipulation, Diagnostic X-rays and lab tests, Physical Speech / Occupational Therapy & Ambulance.	\$610.33	\$1,464.79	\$976.53	\$1,647.89	\$539,776	11.1%	\$54,141
13	Advantage PPO 500 (100/80) \$20/\$30 Office Visit, \$100 Emergency Room, \$10, \$30, \$45 Rx. \$500 / \$1,000 Deductible, 100% Deductible applies to: In Patient / Out Patient, Spinal Manipulation, Diagnostic X-rays and lab tests, Physical Speech / Occupational Therapy & Ambulance.	\$575.45	\$1,381.08	\$920.72	\$1,553.72	\$508,929	4.8%	\$23,295
14	Advantage PPO 1000 (80/60) \$15/\$25 Office Visit, \$100 Emergency Room, \$10, \$30, \$45 Rx. \$1,000 / \$2,000 Deductible, 80% Deductible applies to: In Patient / Out Patient, Spinal Manipulation, Diagnostic X-rays and lab tests, Physical Speech / Occupational Therapy & Ambulance.	\$491.16	\$1,178.78	\$785.86	\$1,326.13	\$434,381	-10.6%	(\$51,253)
15	Advantage PPO Saver (1500/3000) HSA \$1,500 / \$3,000 Deductible, 100%, Deductible Applies to: All services except routine annual preventative services. \$10, \$30, \$45 Rx. Co-payment after deductible.	\$460.85	\$1,106.04	\$737.36	\$1,244.30	\$407,577	-16.1%	(\$78,057)

Medicare Summary of Rates

Effective: July 1, 2011- June 30, 2012

CURRENT PLAN:

Carrier: Blue Cross Blue Shield RI

Plan 65 Rates with Prescription Drug Rider \$7 / \$30 / \$50 = **\$465.15**

RENEWAL PLAN:

Carrier: Blue Cross Blue Shield RI

Plan 65 Rates with Prescription Drug Rider \$7 / \$30 / \$50 = **\$552.03**

- Plan Options -

OPTION #1:

Carrier: Blue Cross Blue Shield RI

Plan 65 Rates with Prescription Drug Rider 20% = **\$519.39**

OPTION #2:

Carrier: Blue Cross Blue Shield RI

Plan 65 Rates with Prescription Drug Rider \$5 / \$15 / \$30 / \$30 = **\$643.27**

Health Plan Comparison	Blue Cross Blue Shield HMC2C 15/25 (R1) Company Plan		Blue Cross Blue Shield VantageBlue 100/80 \$250 Ded New Rx Company Renewal Plan
	Current	Renewal	
	\$485,634 N/A N/A	N/A N/A N/A	\$500,662 3.1% \$15,028
Estimated Annual Premium			
% Renewal Increase (Decrease)			
\$ Renewal Increase (Decrease)			
Calendar Year Deductible	None		\$250 / \$500
Out of Pocket Maximum	None		\$750 / \$1,500
Primary Care Provider Necessary	No		No
In Network Services			
HOSPITAL SERVICES:			
Inpatient Semi-private room, related services & supplies	\$0		\$0 After Deductible
Outpatient Procedures & Surgery	\$0		\$0 After Deductible
Emergency Room Services	\$100 Co-payment		\$100 Co-payment
URGENT CARE CENTERS:			
Walk-In Treatment Centers	\$50 Co-payment		\$50 Co-payment
OFFICE VISITS:			
Well Visits	\$0		\$0
Primary Care Physician	\$15 Co-payment		\$15 Co-payment
Specialty Physician	\$25 Co-payment		\$30 Co-payment
Chiropractic / Spinal Manipulation	\$25 Co-payment		\$30 Co-payment
Routine Eye Exam	\$25 Co-payment		\$30 Co-payment
Physical / Speech / Occupational Therapy	20% Co-payment		20% After Deductible
Outpatient Behavioral health / Chemical dependency	\$25 Co-payment		\$30 Co-payment
INDEPENDENT LAB, X-RAY, CLINICS			
Lab and X-Ray Services (Preventative)	\$0		\$0
Lab and X-Ray Services (Diagnostic)	\$0		\$0 After Deductible
Machine Tests (MRI, MRA'S, Pel Scans, CT Scans & Nuclear)	\$0		\$0 After Deductible
PHARMACY SERVICES:			
Prescription Drugs (30 Day Supply) Tier 1	\$7		\$10
Prescription Drugs (30 Day Supply) Tier 2	\$30		\$35
Prescription Drugs (30 Day Supply) Tier 3	\$50		\$60
Prescription Drugs (30 Day Supply) Tier 4	\$75		\$100
Mail Order (90 Day Supply)	\$17.50 / \$75 / \$125 / \$125		\$25 / \$87.50 / \$150 / \$150
OTHER SERVICES:			
Durable Medical Equipment	20% Co-payment		20% After Deductible
Ambulance (Land)	\$50 Co-payment		\$50 Co-payment
OUT OF NETWORK SERVICES:			
Annual Deductible	\$200 / \$600		\$1,000 / \$2,000
Copayment After Deductible	\$15 / \$25 Co-payment Plus 20%		\$15 / \$30 Co-payment Plus 20%
Out of Pocket Limit	\$3,000 / \$9,000		\$3,000 / \$6,000
Maximum Benefit	Unlimited		Unlimited

Health Plan Comparison	Blue Cross Blue Shield HMC26 15/25 (R1) Company Plan		Blue Cross Blue Shield VantageBlue 100/80 \$500 Ded New Rx Option 1	Blue Cross Blue Shield VantageBlue 100/80 \$1,000 Ded New Rx Option 2	Blue Cross Blue Shield \$2,000 / \$4,000 Ded Option 3
	Current \$485,634 N/A N/A	Renewal N/A N/A N/A			
Estimated Annual Premium			\$470,520	\$427,915	\$365,838
% Renewal Increase (Decrease)			-3.1%	-11.9%	-24.7%
\$ Renewal Increase (Decrease)			(\$15,114)	(\$57,719)	(\$119,796)
Calendar Year Deductible	None		\$500 / \$1,000	\$1,000 / \$2,000	\$2,000 / \$4,000
Out of Pocket Maximum	None		\$1,500 / \$3,000	\$3,000 / \$6,000	\$2,000 / \$4,000
Primary Care Provider Necessary	No		No	No	No
In Network Services					
HOSPITAL SERVICES:					
Inpatient Semi-private room, related services & supplies	\$0		\$0 After Deductible	\$0 After Deductible	\$0 After Deductible
Outpatient Procedures & Surgery	\$0		\$0 After Deductible	\$0 After Deductible	\$0 After Deductible
Emergency Room Services	\$100 Co-payment		\$100 Co-payment	\$100 Co-payment	\$0 After Deductible
URGENT CARE CENTERS:					
Walk-In Treatment Centers	\$50 Co-payment		\$50 Co-payment	\$50 Co-payment	\$0 After Deductible
OFFICE VISITS:					
Well Visits	\$0		\$0	\$0	\$0
Primary Care Physician	\$15 Co-payment		\$15 Co-payment	\$15 Co-payment	\$0 After Deductible
Specialty Physician	\$25 Co-payment		\$30 Co-payment	\$30 Co-payment	\$0 After Deductible
Chiropractic / Spinal Manipulation	\$25 Co-payment		\$30 Co-payment	\$30 Co-payment	\$0 After Deductible
Routine Eye Exam	\$25 Co-payment		\$30 Co-payment	\$30 Co-payment	\$0 After Deductible
Physical / Speech / Occupational Therapy	20% Co-payment		20% After Deductible	20% After Deductible	\$0 After Deductible
Outpatient Behavioral health / Chemical dependency	\$25 Co-payment		\$30 Co-payment	\$30 Co-payment	\$0 After Deductible
INDEPENDENT LAB, X-RAY, CLINICS					
Lab and X-Ray Services (Preventative)	\$0		\$0	\$0	\$0
Lab and X-Ray Services (Diagnostic)	\$0		\$0 After Deductible	\$0 After Deductible	\$0 After Deductible
Machine Tests (MRI, MRA'S, Pet Scans, CT Scans & Nuclear)	\$0		\$0 After Deductible	\$0 After Deductible	\$0 After Deductible
PHARMACY SERVICES:					
Prescription Drugs (30 Day Supply) Tier 1	\$7		\$10	\$10	\$7
Prescription Drugs (30 Day Supply) Tier 2	\$30		\$35	\$35	\$30
Prescription Drugs (30 Day Supply) Tier 3	\$50		\$60	\$60	\$50
Prescription Drugs (30 Day Supply) Tier 4	\$75		\$100	\$100	\$75
Mail Order (90 Day Supply)	\$17.50 / \$75 / \$125 / \$125		\$25 / \$87.50 / \$150 / \$150	\$25 / \$87.50 / \$150 / \$150	\$17.50 / \$75 / \$125 / \$125
OTHER SERVICES:					
Durable Medical Equipment	20% Co-payment		20% After Deductible	20% After Deductible	\$0 After Deductible
Ambulance (Land)	\$50 Co-payment		\$50 Co-payment	\$50 Co-payment	\$0 After Deductible
OUT OF NETWORK SERVICES:					
Annual Deductible	\$200 / \$600		\$1,000 / \$2,000	\$2,000 / \$4,000	\$4,000 / \$8,000
Copayment After Deductible	\$15 / \$25 Co-payment Plus 20%		\$15 / \$30 Co-payment Plus 20%	\$15 / \$30 Co-payment Plus 20%	20%
Out of Pocket Limit	\$3,000 / \$9,000		\$3,000 / \$6,000	\$6,000 / \$12,000	\$8,000 / \$16,000
Maximum Benefit	Unlimited		Unlimited	Unlimited	Unlimited

Health Plan Comparison	Blue Cross Blue Shield HMC2C 15/2S (R1) Company Plan		Blue Cross Blue Shield BlueSolutions for HSA 100/60 (\$1,500/\$3,000) Option 4
	Current	Renewal	
	\$485,634 N/A N/A	N/A N/A N/A	\$395,255 -18.6% (\$90,380)
Estimated Annual Premium			
% Renewal Increase (Decrease)			
\$ Renewal Increase (Decrease)			
Calendar Year Deductible	None		\$1,500 / \$3,000
Out of Pocket Maximum	None		\$3,000 / \$6,000
Primary Care Provider Necessary	No		No
In Network Services			
HOSPITAL SERVICES:			
Inpatient Semi-private room, related services & supplies	\$0		\$0 After Deductible
Outpatient Procedures & Surgery	\$0		\$0 After Deductible
Emergency Room Services	\$100 Co-payment		\$0 After Deductible
URGENT CARE CENTERS:			
Walk-In Treatment Centers	\$50 Co-payment		\$0 After Deductible
OFFICE VISITS:			
Well Visits	\$0		\$0
Primary Care Physician	\$15 Co-payment		\$0 After Deductible
Specialty Physician	\$25 Co-payment		\$0 After Deductible
Chiropractic / Spinal Manipulation	\$25 Co-payment		\$0 After Deductible
Routine Eye Exam	\$25 Co-payment		\$0 After Deductible
Physical / Speech / Occupational Therapy	20% Co-payment		\$0 After Deductible
Outpatient Behavioral health / Chemical dependency	\$25 Co-payment		\$0 After Deductible
INDEPENDENT LAB, X-RAY, CLINICS			
Lab and X-Ray Services (Preventative)	\$0		\$0
Lab and X-Ray Services (Diagnostic)	\$0		\$0 After Deductible
Machine Tests (MRI, MRA'S, Pet Scans, CT Scans & Nuclear)	\$0		\$0 After Deductible
PHARMACY SERVICES:			
Prescription Drugs (30 Day Supply) Tier 1	\$7		\$10 After Deductible
Prescription Drugs (30 Day Supply) Tier 2	\$30		\$35 After Deductible
Prescription Drugs (30 Day Supply) Tier 3	\$50		\$60 After Deductible
Prescription Drugs (30 Day Supply) Tier 4	\$75		\$100 After Deductible
Mail Order (90 Day Supply)	\$17.50 / \$75 / \$125 / \$125		\$25 / \$87.50 / \$150 After Deductible
OTHER SERVICES:			
Durable Medical Equipment	20% Co-payment		\$0 After Deductible
Ambulance (Land)	\$50 Co-payment		\$0 After Deductible
OUT OF NETWORK SERVICES:			
Annual Deductible	\$200 / \$600		\$1,500 / \$3,000
Copayment After Deductible	\$15 / \$25 Co-payment Plus 20%		40% After Deductible
Out of Pocket Limit	\$3,000 / \$9,000		\$3,000 / \$6,000
Maximum Benefit	Unlimited		Unlimited

Health Plan Comparison	Blue Cross Blue Shield		United Healthcare		United Healthcare		United Healthcare	
	HMC2C 15/25 (R1)		U8T (H9)		U8V (H9)		U8U (H9)	
	Company Plan		Option 5		Option 6		Option 7	
	Current	Renewal						
Estimated Annual Premium	\$485,634	N/A	\$529,668		\$492,384		\$490,244	
% Renewal Increase (Decrease)	N/A	N/A	9.1%		1.4%		0.9%	
\$ Renewal Increase (Decrease)	N/A	N/A	\$44,034		\$6,750		\$4,610	
Calendar Year Deductible	None		None		None		\$300 / \$600	
Out of Pocket Maximum	None		None		None		\$300 / \$500	
Primary Care Provider Necessary	No		No		No		No	
IN-NETWORK SERVICES								
HOSPITAL SERVICES:								
Inpatient Semi-private room, related services & supplies	\$0		\$0		\$0		\$0 After Deductible	
Outpatient Procedures & Surgery	\$0		\$0		\$0		\$0 After Deductible	
Emergency Room Services	\$100 Co-payment		\$100 Co-payment		\$125 Co-payment		\$100 Co-payment	
URGENT CARE CENTERS:								
Walk-In Treatment Centers	\$50 Co-payment		\$25 Co-payment		\$50 Co-payment		\$25 Co-payment	
OFFICE VISITS:								
Well Visits	\$0		\$0		\$0		\$0	
Primary Care Physician	\$15 Co-payment		\$10 Co-payment		\$20 Co-payment		\$15 Co-payment	
Specialty Physician	\$25 Co-payment		\$10 Co-payment		\$30 Co-payment		\$15 Co-payment	
Chiropractic / Spinal Manipulation	\$25 Co-payment		\$10 Co-payment		\$20 Co-payment		\$15 Co-payment	
Routine Eye Exam	\$25 Co-payment		\$10 Co-payment		\$20 Co-payment		\$15 Co-payment	
Physical / Speech / Occupational Therapy	20% Co-payment		\$10 Co-payment		\$20 Co-payment		\$15 Co-payment	
Outpatient Behavioral health / Chemical dependency	\$25 Co-payment		\$10 Co-payment		\$30 Co-payment		\$15 Co-payment	
INDEPENDENT LAB, X-RAY, CLINICS								
Lab and X-Ray Services (Preventative)	\$0		\$0		\$0		\$0	
Lab and X-Ray Services (Diagnostic)	\$0		\$0		\$0		\$0	
Machine Tests (MRI, MRA'S, Pet Scans, CT Scans & Nuclear)	\$0		\$0		\$500 Co-payment		\$0 After Deductible	
PHARMACY SERVICES								
Prescription Drugs (30 Day Supply) Tier 1	\$7		\$10		\$10		\$10	
Prescription Drugs (30 Day Supply) Tier 2	\$30		\$30		\$30		\$30	
Prescription Drugs (30 Day Supply) Tier 3	\$50		\$50		\$50		\$50	
Prescription Drugs (30 Day Supply) Tier 4	\$75		None		None		None	
Mail Order (90 Day Supply)	\$17.50 / \$75 / \$125 / \$125		\$25 / \$75 / \$125		\$25 / \$75 / \$125		\$25 / \$75 / \$125	
OTHER SERVICES:								
Durable Medical Equipment	20% Co-payment		\$0		\$0		\$0 After Deductible	
Ambulance (Land)	\$50 Co-payment		\$0		\$50 Co-Payment		\$50 Co-payment	
OUT OF NETWORK SERVICES:								
Annual Deductible	\$200 / \$600		\$350 / \$700		\$350 / \$700		\$350 / \$700	
Copayment After Deductible	\$15 / \$25 Co-payment Plus 20%		20% After Deductible		20% After Deductible		30% After Deductible	
Out of Pocket Limit	\$3,000 / \$9,000		\$2,850 / \$5,700		\$2,850 / \$5,700		\$4,350 / \$8,700	
Maximum Benefit	Unlimited		Unlimited		Unlimited		Unlimited	

Health Plan Comparison	Blue Cross Blue Shield		United Healthcare	United Healthcare	United Healthcare
	HMC2C 15/25 (R1)		UBW (H9)	1RB (H9)	HSA - U16 (H9)
	Contributory Plan		Option B	Option 9	Option 10
	Current	Renewal			
Estimated Annual Premium	\$485,634	N/A	\$466,365	\$354,932	\$357,384
% Renewal Increase (Decrease)	N/A	N/A	-4.0%	-26.9%	-26.4%
\$ Renewal Increase (Decrease)	N/A	N/A	(\$19,269)	(\$130,702)	(\$128,250)
Calendar Year Deductible	None		\$500 / \$1,000	\$2,000 / \$4,000	\$1,500 / \$3,000
Out of Pocket Maximum	None		\$500 / \$1,000	\$2,000 / \$4,000	\$3,000 / \$6,000
Primary Care Provider Necessary	No		No	No	No
In Network Services					
HOSPITAL SERVICES:					
Inpatient Semi-private room, related services & supplies	\$0		\$0 After Deductible	\$0 After Deductible	\$0 After Deductible
Outpatient Procedures & Surgery	\$0		\$0 After Deductible	\$0 After Deductible	\$0 After Deductible
Emergency Room Services	\$100 Co-payment		\$100 Co-payment	\$0 After Deductible	\$0 After Deductible
URGENT CARE CENTERS:					
Walk-In Treatment Centers	\$50 Co-payment		\$50 Co-payment	\$0 After Deductible	\$0 After Deductible
OFFICE VISITS:					
Well Visits	\$0		\$0	\$0	\$0
Primary Care Physician	\$15 Co-payment		\$20 Co-payment	\$0 After Deductible	\$0 After Deductible
Specialty Physician	\$25 Co-payment		\$20 Co-payment	\$0 After Deductible	\$0 After Deductible
Chiropractic / Spinal Manipulation	\$25 Co-payment		\$20 Co-payment	\$0 After Deductible	\$0 After Deductible
Routine Eye Exam	\$25 Co-payment		\$20 Co-payment	\$0 After Deductible	\$0 After Deductible
Physical / Speech / Occupational Therapy	20% Co-payment		\$20 Co-payment	\$0 After Deductible	\$0 After Deductible
Outpatient Behavioral health / Chemical dependency	\$25 Co-payment		\$20 Co-payment	\$0 After Deductible	\$0 After Deductible
INDEPENDENT LAB, X-RAY, CLINICS					
Lab and X-Ray Services (Preventative)	\$0		\$0	\$0	\$0
Lab and X-Ray Services (Diagnostic)	\$0		\$0	\$0 After Deductible	\$0 After Deductible
Machine Tests (MRI, MRA'S, Pet Scans, CT Scans & Nuclear)	\$0		\$0 After Deductible	\$0 After Deductible	\$0 After Deductible
PHARMACY SERVICES:					
Prescription Drugs (30 Day Supply) Tier 1	\$7		\$10	\$10	\$10
Prescription Drugs (30 Day Supply) Tier 2	\$30		\$30	\$30	\$30
Prescription Drugs (30 Day Supply) Tier 3	\$50		\$50	\$50	\$50
Prescription Drugs (30 Day Supply) Tier 4	\$75		None	None	None
Mail Order (90 Day Supply)	\$17.50 / \$75 / \$125 / \$125		\$25 / \$75 / \$125	\$25 / \$75 / \$125	\$25 / \$75 / \$125
OTHER SERVICES:					
Durable Medical Equipment	20% Co-payment		\$0 After Deductible	\$0 After Deductible	\$0 After Deductible
Ambulance (Land)	\$50 Co-payment		\$50 Co-payment	\$50 Co-payment	\$0 After Deductible
OUT OF NETWORK SERVICES:					
Annual Deductible	\$200 / \$600		\$1,000 / \$2,000	\$4,000 / \$8,000	\$3,000 / \$6,000
Copayment After Deductible	\$15 / \$25 Co-payment Plus 20%		20% After Deductible	20% After Deductible	20% After Deductible
Out of Pocket Limit	\$3,000 / \$9,000		\$4,000 / \$8,000	\$8,000 / \$16,000	\$6,000 / \$12,000
Maximum Benefit	Unlimited		Unlimited	Unlimited	Unlimited

Health Plan Comparison	Blue Cross Blue Shield		Tufts	Tufts	Tufts
	HMC2C 15/25 (R1)		PPO Choice 15/25	Advantage PPO 250 (100/80)	Advantage PPO 500 (100/80)
	Company Plan		Option 11	Option 12	Option 13
	Current	Renewal			
Estimated Annual Premium	\$485,634	N/A	\$570,137	\$539,776	\$508,929
% Renewal Increase (Decrease)	N/A	N/A	17.4%	11.1%	4.8%
\$ Renewal Increase (Decrease)	N/A	N/A	\$84,503	\$54,141	\$23,295
Calendar Year Deductible	None	None	None	\$250 / \$500	\$500 / \$1,000
Out of Pocket Maximum	None	None	None	\$1,250 / \$2,500	\$1,500 / \$3,000
Primary Care Provider Necessary	No	No	No	No	No
IN-NETWORK SERVICES					
HOSPITAL SERVICES:					
Inpatient Semi-private room, related services & supplies	\$0	\$0	\$0	\$0 After Deductible	\$0 After Deductible
Outpatient Procedures & Surgery	\$0	\$0	\$0	\$0 After Deductible	\$0 After Deductible
Emergency Room Services	\$100 Co-payment	\$100 Co-payment	\$100 Co-payment	\$100 Co-payment	\$100 Co-payment
URGENT CARE CENTERS:					
Walk-In Treatment Centers	\$50 Co-payment	\$25 Co-payment	\$25 Co-payment	\$25 Co-payment	\$30 Co-payment
OFFICE VISITS:					
Well Visits	\$0	\$0	\$0	\$0	\$0
Primary Care Physician	\$15 Co-payment	\$15 Co-payment	\$15 Co-payment	\$15 Co-payment	\$20 Co-payment
Specialty Physician	\$25 Co-payment	\$25 Co-payment	\$25 Co-payment	\$25 Co-payment	\$30 Co-payment
Chiropractic / Spinal Manipulation	\$25 Co-payment	\$25 Co-payment	\$25 Co-payment	\$0 After Deductible	\$0 After Deductible
Routine Eye Exam	\$25 Co-payment	\$15 Co-payment	\$15 Co-payment	\$15 Co-payment	\$20 Co-payment
Physical / Speech / Occupational Therapy	20% Co-payment	\$25 Co-payment	\$25 Co-payment	\$0 After Deductible	\$0 After Deductible
Outpatient Behavioral health / Chemical dependency	\$25 Co-payment	\$15 Co-payment	\$15 Co-payment	\$15 Co-payment	\$20 Co-payment
INDEPENDENT LAB, X-RAY, CLINICS					
Lab and X-Ray Services (Preventative)	\$0	\$0	\$0	\$0	\$0
Lab and X-Ray Services (Diagnostic)	\$0	\$0	\$0	\$0 After Deductible	\$0 After Deductible
Machine Tests (MRI, MRA'S, Pet Scans, CT Scans & Nuclear)	\$0	\$0	\$0	\$0 After Deductible	\$0 After Deductible
PHARMACY SERVICES:					
Prescription Drugs (30 Day Supply) Tier 1	\$7	\$10	\$10	\$10	\$10
Prescription Drugs (30 Day Supply) Tier 2	\$30	\$25	\$25	\$30	\$30
Prescription Drugs (30 Day Supply) Tier 3	\$50	\$45	\$45	\$45	\$45
Prescription Drugs (30 Day Supply) Tier 4	\$75	None	None	None	None
Mail Order (90 Day Supply)	\$17.50 / \$75 / \$125 / \$125	\$20 / \$50 / \$90	\$20 / \$50 / \$90	\$20 / \$60 / \$90	\$20 / \$60 / \$90
OTHER SERVICES:					
Durable Medical Equipment	20% Co-payment	\$0 (\$1,500 max)	\$0 (\$1,500 max)	\$0 (\$1,500 max)	\$0 (\$1,500 max)
Ambulance (Land)	\$50 Co-payment	\$0	\$0	\$0 After Deductible	\$0 After Deductible
OUT OF NETWORK SERVICES:					
Annual Deductible	\$200 / \$600	\$500 / \$1,000	\$250 / \$500	\$250 / \$500	\$500 / \$1,000
Copayment After Deductible	\$15 / \$25 Co-payment Plus 20%	20%	20%	20%	20%
Out of Pocket Limit	\$3,000 / \$9,000	\$2,500 / \$5,000	\$4,000 / \$8,000	\$4,000 / \$8,000	\$4,000 / \$8,000
Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

Health Plan Comparison	Blue Cross Blue Shield		Tufts	
	HMC2C 15/25 (R1)		Advantage PPO 1000 (80/60)	Advantage PPO Saver (1500/3000)
	Company Plan		Option 14	HSA Option 15
	Current	Renewal		
Estimated Annual Premium	\$485,634	N/A	\$434,381	\$407,577
% Renewal Increase (Decrease)	N/A	N/A	-10.6%	-16.1%
\$ Renewal Increase (Decrease)	N/A	N/A	(\$51,253)	(\$78,057)
Calendar Year Deductible		None	\$1,000 / \$2,000	\$1,500 / \$3,000
Out of Pocket Maximum		None	\$4,000 / \$8,000	\$4,125 / \$8,250
Primary Care Provider Necessary		No	No	No
In Network Services				
HOSPITAL SERVICES:				
Inpatient Semi-private room, related services & supplies		\$0	20% After Deductible	\$0 After Deductible
Outpatient Procedures & Surgery		\$0	20% After Deductible	\$0 After Deductible
Emergency Room Services		\$100 Co-payment	\$100 Co-payment	\$0 After Deductible
URGENT CARE CENTERS:				
Walk-In Treatment Centers		\$50 Co-payment	\$25 Co-payment	\$0 After Deductible
OFFICE VISITS:				
Well Visits		\$0	\$0	\$0
Primary Care Physician		\$15 Co-payment	\$15 Co-payment	\$0 After Deductible
Specialty Physician		\$25 Co-payment	\$25 Co-payment	\$0 After Deductible
Chiropractic / Spinal Manipulation		\$25 Co-payment	20% After Deductible	\$0 After Deductible
Routine Eye Exam		\$25 Co-payment	\$15 Co-payment	\$20 Co-payment
Physical / Speech / Occupational Therapy		20% Co-payment	20% After Deductible	\$0 After Deductible
Outpatient Behavioral health / Chemical dependency		\$25 Co-payment	\$15 Co-payment	\$0 After Deductible
INDEPENDENT LAB, X-RAY, CLINICS				
Lab and X-Ray Services (Preventative)		\$0	\$0	\$0
Lab and X-Ray Services (Diagnostic)		\$0	20% After Deductible	\$0 After Deductible
Machine Tests (MRI, MRA'S, Pet Scans, CT Scans & Nuclear)		\$0	20% After Deductible	\$0 After Deductible
PHARMACY SERVICES:				
Prescription Drugs (30 Day Supply) Tier 1		\$7	\$10	\$10 After Deductible
Prescription Drugs (30 Day Supply) Tier 2		\$30	\$30	\$30 After Deductible
Prescription Drugs (30 Day Supply) Tier 3		\$50	\$45	\$45 After Deductible
Prescription Drugs (30 Day Supply) Tier 4		\$75	None	None
Mail Order (90 Day Supply)		\$17.50 / \$75 / \$125 / \$125	\$20 / \$60 / \$90	\$20 / \$60 / \$90 After Deductible
OTHER SERVICES:				
Durable Medical Equipment		20% Co-payment	\$0 (1,500 max)	\$0 After Deductible (\$1,500 max)
Ambulance (Land)		\$50 Co-payment	20% After Deductible	\$0 After Deductible
OUT-OF-NETWORK SERVICES:				
Annual Deductible		\$200 / \$600	\$1,000 / \$2,000	\$1,500 / \$3,000
Copayment After Deductible		\$15 / \$25 Co-payment Plus 20%	40%	20%
Out of Pocket Limit		\$3,000 / \$9,000	\$6,000 / \$12,000	\$4,125 / \$8,250
Maximum Benefit		Unlimited	Unlimited	Unlimited

Plan 65[®]

Medicare Supplement

Group Plan 65 is a Medicare supplement plan, also known as "Medigap," that picks up where Medicare leaves off, making it easier for you to budget for your healthcare expenses. Group Plan 65 provides flexibility, options, and added discounts—all from a trusted, local company.

You're free to seek care from the Original Medicare-participating providers of your choice, anywhere in the country. Plan 65 pays for Original Medicare's cost-sharing, such as deductibles and coinsurance. If Original Medicare does not cover a service, your supplemental plan will also not cover that service, unless otherwise noted.

PLAN BENEFIT	With Original Medicare you pay:	With Medicare and Group Plan 65 you pay:
Doctor Visits (Inpatient and outpatient)	20% of Medicare-approved amounts after Part B deductible	\$0
Inpatient Hospital Care* (Includes substance abuse, mental health, rehabilitation, and inpatient surgery facility services)		
• First 60 days	An initial deductible of \$1,132**	\$0
• 61 st – 90 th day	\$283 each day**	\$0
• 60 lifetime reserve days	\$566 each lifetime reserve day**	\$0
• Additional lifetime maximum benefit – 365 days	All costs	\$0
Skilled Nursing Facility Care* (In Medicare-certified skilled nursing facility)		
• First 20 days	\$0	\$0
• 21 st – 100 th day	\$141.50 each day**	\$0
• 101 st day and after	All costs	All costs
Outpatient Surgery Services	20% of Medicare-approved amounts after Part B deductible	\$0
Outpatient Rehabilitation Services	20% of Medicare-approved amounts after Part B deductible	\$0
Emergency Room Care (You may go to an emergency room if you believe your health is in serious danger.)	20% of Medicare-approved amounts after Part B deductible	\$0
Urgently Needed Care (This is not emergency care—your health is not in serious danger.)	20% of Medicare-approved amounts after Part B deductible	\$0
Ambulance Services	20% of Medicare-approved amounts after Part B deductible	\$0
Diagnostic Tests, X-rays, and Lab Services	20% of Medicare-approved amounts after Part B deductible for diagnostic tests and X-rays \$0 for Medicare-covered lab services	\$0
Durable Medical Equipment	20% of Medicare-approved amounts after Part B deductible	\$0
Prosthetic Devices	20% of Medicare-approved amounts after Part B deductible	\$0

PLAN BENEFIT	With Original Medicare you pay:	With Medicare and Group Plan 65 you pay:
Home Healthcare	\$0 for Medicare-covered home health visits	\$0
Foreign Travel Care	All costs	20% of charges, after \$250 annual deductible
Non-routine Hearing Services	20% of Medicare-approved amounts after Part B deductible for diagnostic hearing exams	\$0 for Medicare-approved amounts for diagnostic hearing exams
Non-routine Vision Care	20% of Medicare-approved amounts after Part B deductible for diagnosis and treatment of disease and conditions of the eye	\$0
Podiatry Services	20% of Medicare-approved amounts after Part B deductible	\$0
Chiropractic Services	20% of Medicare-approved amounts after Part B deductible	\$0
Immunizations (Flu, hepatitis B vaccine, and, for people with Medicare who are at high risk, pneumonia vaccine)	\$0	\$0
Bone Mass Measurement (For people with Medicare who are at risk)	\$0	\$0
Colorectal Screening Exams	\$0 May be charged 20% of the Medicare approved amount for doctor's visit	\$0
Diabetes Screening (For people with Medicare who are at risk)	\$0 May be charged 20% of the Medicare approved amount for doctor's visit	\$0
Mammography Screening (Diagnostic and radiological mammograms for men and women)	\$0	\$0
Pap Tests and Pelvic Exams (For women with Medicare)	\$0	\$0
Prostate Cancer Screening Exams (For men with Medicare)	20% of Medicare approved amount for digital rectal exam. May be charged 20% of the Medicare approved amount for doctor's visit.	\$0

2011 Part A Deductible = \$1,132 per benefit period.
2011 Part B Deductible = \$162 per calendar year.

All services should be received from an Original Medicare-participating provider, except in emergencies.

To be eligible for Group Plan 65, you must be enrolled in both Part A and Part B of the Original Medicare Program.

* A benefit period begins on the first day you receive services as an inpatient in a hospital, and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 consecutive days.

** These coinsurances and deductibles are current for 2011 and are subject to change on an annual basis.

Your Prescription Drug Plan – Group Plan 65

We are pleased to present you with your prescription drug plan. The following information will help you understand your prescription drug benefits.

How does my prescription drug benefit work?

You can have your prescription filled at any of our participating pharmacies and you will be responsible only for your copayment at the time of purchase.

Some brand name drugs have generic equivalents. If a drug has a generic equivalent, your prescription drug plan covers the retail cost of the generic drug, less your applicable copayment. If you choose to purchase the brand name drug, you will be responsible for the difference in cost between the brand name drug and its generic equivalent. See "Saving money at the pharmacy" for more information about generic equivalents.

What is my copayment?

You can receive up to a 30-day supply of either maintenance or non-maintenance drugs at the pharmacy. Your copayment is **20% of the retail prescription cost**. If you choose a brand name medication over an available generic equivalent, you will be responsible for the difference in cost between the two.

Where can I have my prescriptions filled?

Our extensive national network includes most major chain stores and independent pharmacies. Visit any participating pharmacy at any time to receive maximum coverage under your prescription drug program. For more information about participating pharmacies, visit our Web site at www.BCBSRI.com, or refer to your pharmacy directory.

Out-of-network pharmacies

If you have your prescription filled at a non-participating pharmacy, you must pay for it in full when you have it filled. You will be reimbursed at 50% of our allowance. Remember, using a non-participating pharmacy means a higher out-of-pocket expense to you.

Save money at the pharmacy

You can maximize your pharmacy benefit and substantially lower your out-of-pocket cost by choosing generic drugs. While you may not be familiar with the name, a generic drug is essentially the same drug as its higher priced, heavily advertised, brand name equivalent. It has the same active ingredients and is approved by the Food & Drug Administration (FDA). It has passed rigorous tests to ensure that it's as safe and effective as its brand name equivalent. Discuss your prescription drug options with your doctor to ensure the best possible course of treatment. If a brand name drug is prescribed, ask your doctor or pharmacist if a generic alternative is available.

Have your prescriptions delivered to your door with our mail service

Most drugs that you may take for an extended period of time can be purchased through our mail order program for your convenience. You can order a maximum of up to a 90-day supply of most medications with a 20% copayment of the total retail cost. You should receive your first supply within two weeks of submitting your order. You can order refills 24 hours a day, seven days a week by telephone or on the Internet at www.BCBSRI.com. For additional information, see www.BCBSRI.com or your mail order brochure.

(Continued on back)



Your Plan for Life.™

Infertility and injectable drugs

- Infertility drugs, including oral and injectable drugs, are covered with a 20% copayment.
- Insulin is covered with a 20% copayment.
- Other injectables purchased at the pharmacy are covered with a 20% copayment.

Preferred drug list (formulary)

A formulary is a list of **preferred drugs** that are covered by your plan. A committee of local physicians and pharmacists, established by Blue Cross & Blue Shield of Rhode Island (BCBSRI), developed our drug formulary to ensure that our members have access to a wide range of medically effective, safe, and economical drugs.

Our review committee will consider new drugs for possible inclusion in our preferred drug list (formulary). New drugs will be reviewed within the first six months from the final FDA marketing approval date. A new drug will not be covered by BCBSRI before the committee has the opportunity to review the new drug and make a determination as to whether it is appropriate for inclusion in the preferred drug list.

Additional information about your prescription drug plan

Information is included in your subscriber agreement to help you understand quantity limits that may be applied to “days supply” of medications and to the “forms” in which covered medications may be available (e.g., tablet, capsule).

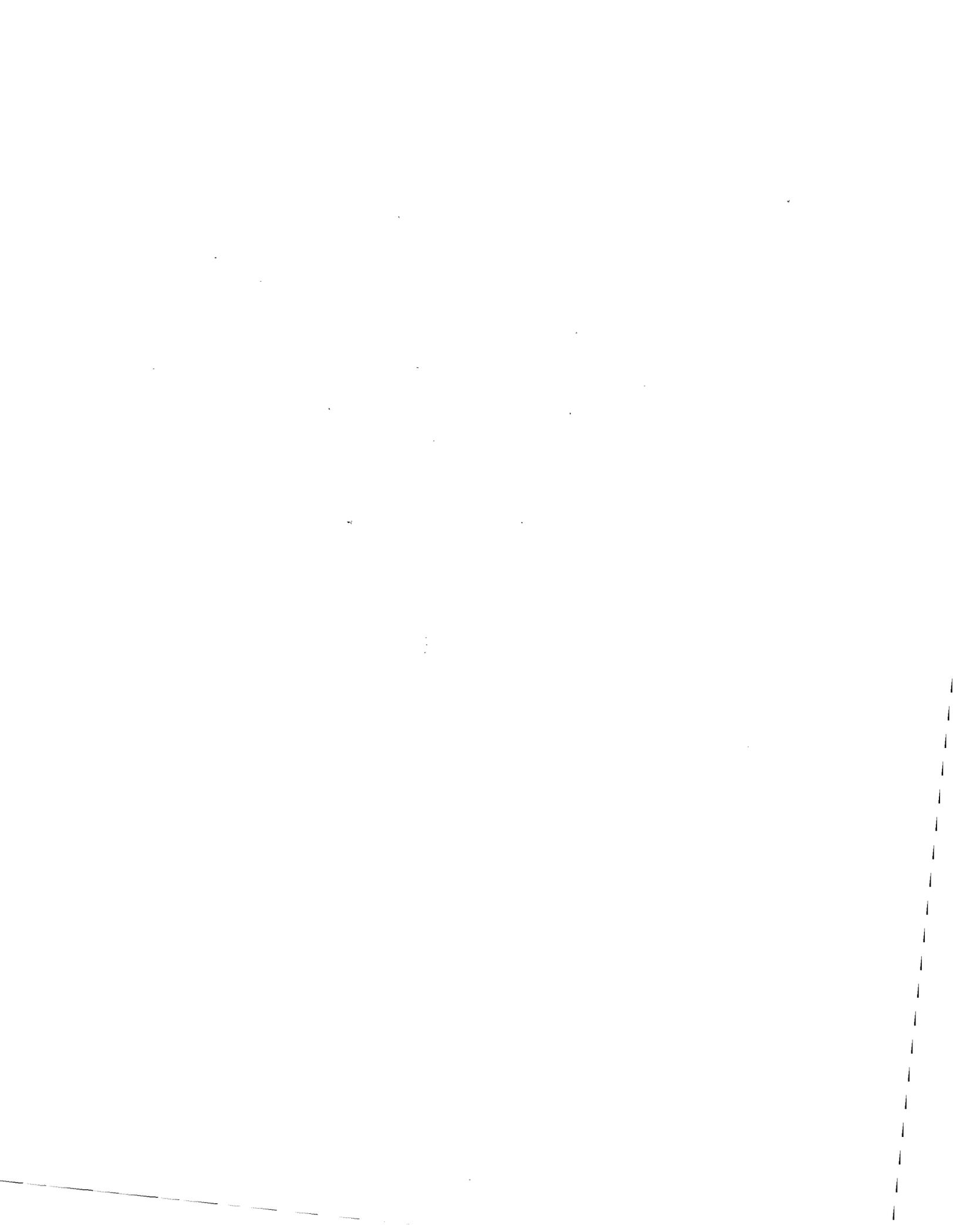
This insert provides a general summary of your prescription drug program. It is not a contract. For details of your coverage, including any limitations or exclusions not noted here, please refer to your subscriber agreement. If you have any questions about coverage for a specific drug or any other questions related to your prescription drug program, please call Customer Service at (401) 459-5000 or 1-800-639-2227.



Your Plan for Life.™

www.BCBSRI.com

444 Westminster Street • Providence, RI 02903-3279



Kent County Water Authority
Financial Analysis
Rates Effective: July 01, 2011 - June 30, 2012

		Single 6	Emp. & Sp. 0	Emp. & Ch. 0	Family 25	Estimated Annualized Premium	% Renewal Increase (Decrease)	\$ Renewal Increase (Decrease)	
CARRIER:		Contracts	Contracts	Contracts	Contracts				
Company Sponsored Plan	Blue Cross & Blue Shield								
	Premier Blue Option 2 100% Preventive / Diagnostic, Minor Restorative & Sealants, 50% Major Restorative & Periodontics. \$50 Calendar Year Deductible Per Member, \$1200 Calendar Year Maximum.	Current Rates Current Enrollment	\$33.27 6	\$95.62 0	\$95.62 0	\$95.62 25	\$31,081	N/A	N/A
Company Sponsored Plan	Premier Blue Option 2 100% Preventive / Diagnostic, Minor Restorative & Sealants, 50% Major Restorative & Periodontics. \$50 Calendar Year Deductible Per Member, \$1200 Calendar Year Maximum.	Renewal Rates Current Enrollment	\$34.37 6	\$104.51 0	\$104.00 0	\$104.51 25	\$33,828	8.8%	\$2,746

Rates are based on the census data and employer contributions provided.
All rates are subject to change if significant modifications are made to either upon enrollment.