

	Current BCN HBL HMO		Renewal BCN HBL HMO		Option 1 BCN HBL HMO		Option 2 BCN HMO		Option 3 BCN HMO	
	Count	Monthly Rates	Monthly Rates	Monthly Rates	Monthly Rates	Monthly Rates	Monthly Rates	Monthly Rates		
Single	9	\$435.30	\$446.44	\$441.21	\$484.48	\$462.04				
Two Person	7	\$1,044.72	\$1,071.46	\$1,058.90	\$1,162.75	\$1,108.91				
Family	17	\$1,305.89	\$1,339.32	\$1,323.63	\$1,453.44	\$1,386.13				
Estimated Monthly Premium		\$33,430.87	\$34,286.62	\$33,884.90	\$37,208.05	\$35,484.94				
Estimated Annual Premium		\$401,170.44	\$411,439.44	\$406,618.80	\$446,496.60	\$425,819.28				
Dollar Change		-	\$10,269.00	\$5,448.36	\$45,326.16	\$24,648.84				
Percent Change		-	2.56%	1.36%	11.30%	6.14%				
Deductible		Enhanced	Standard	Enhanced	Standard	Enhanced	Standard	In-Network	In-Network	
Individual		\$1,000	\$3,000	\$1,000	\$3,000	\$1,500	\$4,000	\$1,000	\$1,500	
Family		\$2,000	\$6,000	\$2,000	\$6,000	\$3,000	\$8,000	\$2,000	\$3,000	
Coinsurance										
Individual		80%	70%	80%	70%	80%	70%	80%	80%	
Family		80%	70%	80%	70%	80%	70%	80%	80%	
Coinsurance Annual Maximum										
Individual		\$2,000	\$3,000	\$2,000	\$3,000	\$1,500	\$2,500	\$2,500	\$2,500	
Family		\$4,000	\$6,000	\$4,000	\$6,000	\$3,000	\$5,000	\$5,000	\$5,000	
True Out of Pocket Annual Maximum (TROOP)										
Individual		\$6,600	\$6,600	\$6,600	\$6,600	\$8,150	\$8,150	\$8,150	\$8,150	
Family		\$13,200	\$13,200	\$13,200	\$13,200	\$16,300	\$16,300	\$16,300	\$16,300	
Office Visit										
Primary Physician		\$25.00	\$30.00	\$25.00	\$30.00	\$20.00	\$35.00	\$20.00	\$30.00	
Specialist		\$35.00	\$40.00	\$35.00	\$40.00	\$30.00	\$45.00	\$40.00	\$50.00	
Chiropractic		\$35.00	\$40.00	\$35.00	\$40.00	\$30.00	\$45.00	\$40.00	\$50.00	
Urgent Care		\$35.00	\$50.00	\$35.00	\$50.00	\$35.00	\$50.00	\$50.00	\$60.00	
Hospital Services										
In-Patient Admission		Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	
Surgical Services		Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	
Emergency Room		\$150.00 after Ded	\$150.00 after Ded	\$150.00 after Ded	\$150.00 after Ded	\$250.00 after Ded	\$250.00 after Ded	\$250.00 after Ded	\$250.00 after Ded	
Imaging Services(X-Ray)		Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	
Advanced Imaging Services (Cat Scan/Pet Scan/MRI)		\$150.00 after Ded	\$150.00 after Ded	\$150.00 after Ded	\$150.00 after Ded	\$150.00 after Ded	\$150.00 after Ded	\$150.00 after Ded	\$150.00 after Ded	
Laboratory		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
Ambulance		Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	
Prescription Drugs										
Generic		\$4.00 / \$15.00	\$6.00 / \$25.00	\$4.00 / \$15.00	\$6.00 / \$25.00	\$4.00 / \$15.00	\$6.00 / \$25.00	\$6.00 / \$25.00	\$6.00 / \$25.00	
Preferred Brand		\$40.00	\$50.00	\$40.00	\$50.00	\$40.00	\$50.00	\$50.00	\$50.00	
Non-Preferred Brand		\$80.00	\$80.00	\$80.00	\$80.00	\$80.00	\$80.00	\$80.00	\$80.00	
Preferred Specialty		20% \$200.00	20% \$200.00	20% \$200.00	20% \$200.00	20% \$200.00	20% \$200.00	20% \$200.00	20% \$200.00	
Non-Preferred Specialty		20% \$300.00	20% \$300.00	20% \$300.00	20% \$300.00	20% \$300.00	20% \$300.00	20% \$300.00	20% \$300.00	
Contraceptives		included	included	included	included	included	included	included	included	
Mail Order		3 co-pays less \$10.00	3 co-pays less \$10.00	3 co-pays less \$10.00	3 co-pays less \$10.00	3 co-pays less \$10.00	3 co-pays less \$10.00	3 co-pays less \$10.00	3 co-pays less \$10.00	
Pediatric Dental & Vision		not included	not included	not included	not included	not included	not included	not included	not included	
Dependent Eligibility										
Dependents Eligible end of year at Age		26	26	26	26	26	26	26	26	
Participation requirement		minimum of 2 contracts	minimum of 2 contracts	minimum of 2 contracts	minimum of 2 contracts	minimum of 2 contracts	minimum of 2 contracts	minimum of 2 contracts	minimum of 2 contracts	
Rate Guarantee				1 year		1 year		1 year		

Above rates are not a contractual agreement and any change in assumptions and/or group demographics could affect rates. Benefit descriptions above are for comparison only; plan document will govern. Group will not be bound by any typographical errors contained in this presentation.

True Out of Pocket Annual Maximum(TROOP) includes Deductible, Coinsurance, Pharmacy and any services requiring a co-payment



Medical & Prescription Drug Cost Analysis

		Current BCN HBL HMO		Renewal BCN HBL HMO		Option 1 BCN - H.S.A. HMO	Option 2 BCN - H.S.A. HMO
Count		Monthly Rates		Monthly Rates		Monthly Rates	Monthly Rates
Single	9	\$435.30		\$446.44		\$410.91	\$455.09
Two Person	7	\$1,044.72		\$1,071.46		\$986.19	\$1,092.21
Family	17	\$1,305.89		\$1,339.32		\$1,232.73	\$1,365.26
Estimated Monthly Premium		\$33,430.87		\$34,286.62		\$31,557.93	\$34,950.70
Estimated Annual Premium		\$401,170.44		\$411,439.44		\$378,695.16	\$419,408.40
Dollar Change		-		\$10,269.00		(\$22,475.28)	\$18,237.96
Percent Change		-		2.56%		-5.60%	4.55%
Deductible		Enhanced	Standard	Enhanced	Standard	In-Network	In-Network
Individual		\$1,000	\$3,000	\$1,000	\$3,000	\$1,400	\$1,400
Family		\$2,000	\$6,000	\$2,000	\$6,000	\$2,800	\$2,800
Coinsurance							
Individual		80%	70%	80%	70%	80%	100%
Family		80%	70%	80%	70%	80%	100%
Coinsurance Annual Maximum							
Individual		\$2,000	\$3,000	\$2,000	\$3,000	\$2,600	N/A
Family		\$4,000	\$6,000	\$4,000	\$6,000	\$5,200	N/A
True Out of Pocket Annual Maximum (TROOP)							
Individual		\$6,600	\$6,600	\$6,600	\$6,600	\$4,000	\$4,000
Family		\$13,200	\$13,200	\$13,200	\$13,200	\$8,000	\$8,000
Office Visit							
Primary Physician		\$25.00	\$30.00	\$25.00	\$30.00	Ded+Coin	Ded
Specialist		\$35.00	\$40.00	\$35.00	\$40.00	Ded+Coin	Ded
Chiropractic		\$35.00	\$40.00	\$35.00	\$40.00	Ded+Coin	Ded
Urgent Care		\$35.00	\$50.00	\$35.00	\$50.00	Ded+Coin	Ded
Hospital Services							
In-Patient Admission		Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded
Surgical Services		Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded
Emergency Room		\$150.00 after Ded	\$150.00 after Ded	\$150.00 after Ded	\$150.00 after Ded	Ded+Coin	Ded
Imaging Services(X-Ray)		Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded
Advanced Imaging Services (Cat Scan/Pet Scan/MRI)		\$150.00 after Ded	\$150.00 after Ded	\$150.00 after Ded	\$150.00 after Ded	Ded+Coin	Ded
Laboratory		\$0.00	\$0.00	\$0.00	\$0.00	Ded+Coin	Ded
Ambulance		Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded
Prescription Drugs						*Co-pays after ded	*Co-pays after ded
Generic		\$4.00 / \$15.00	\$6.00 / \$25.00	\$4.00 / \$15.00	\$6.00 / \$25.00	\$6.00 / \$25.00	\$6.00 / \$25.00
Preferred Brand		\$40.00	\$50.00	\$40.00	\$50.00	\$50.00	\$50.00
Non-Preferred Brand		\$80.00	\$80.00	\$80.00	\$80.00	\$80.00	\$80.00
Preferred Specialty		20% \$200.00	20% \$200.00	20% \$200.00	20% \$200.00	20% \$200.00	20% \$200.00
Non-Preferred Specialty		20% \$300.00	20% \$300.00	20% \$300.00	20% \$300.00	20% \$300.00	20% \$300.00
Contraceptives		included	included	included	included	included	included
Mail Order		3 co-pays less \$10.00	3 co-pays less \$10.00	3 co-pays less \$10.00	3 co-pays less \$10.00	3 co-pays less \$10.00	3 co-pays less \$10.00
Pediatric Dental & Vision		not included	not included	not included	not included	not included	not included
Dependent Eligibility							
Dependents Eligible end of year at Age		26	26	26	26	26	26
Participation requirement		minimum of 2 contracts		minimum of 2 contracts		minimum of 2 contracts	minimum of 2 contracts
Rate Guarantee				1 year		1 year	1 year

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True Out of Pocket Annual Maximum(TROOP) includes Deductible, Coinsurance, Pharmacy and any services requiring a co-payment



Medical & Prescription Drug Cost Analysis

		Current BCN HBL HMO		Renewal BCN HBL HMO		Option 1 Priority Health - Health By Choice HMO	
Count		Monthly Rates		Monthly Rates		Monthly Rates	
Single	9	\$435.30		\$446.44		\$578.81	
Two Person	7	\$1,044.72		\$1,071.46		\$1,389.13	
Family	17	\$1,305.89		\$1,339.32		\$1,736.42	
Estimated Monthly Premium		\$33,430.87		\$34,286.62		\$44,452.34	
Estimated Annual Premium		\$401,170.44		\$411,439.44		\$533,428.08	
Dollar Change		-		\$10,269.00		\$132,257.64	
Percent Change		-		2.56%		32.97%	
Deductible		Enhanced	Standard	Enhanced	Standard	Enhanced	Standard
Individual		\$1,000	\$3,000	\$1,000	\$3,000	\$1,000	\$3,000
Family		\$2,000	\$6,000	\$2,000	\$6,000	\$2,000	\$6,000
Coinsurance							
Individual		80%	70%	80%	70%	80%	70%
Family		80%	70%	80%	70%	80%	70%
Coinsurance Annual Maximum							
Individual		\$2,000	\$3,000	\$2,000	\$3,000	\$2,500	\$2,500
Family		\$4,000	\$6,000	\$4,000	\$6,000	\$5,000	\$5,000
True Out of Pocket Annual Maximum (TROOP)							
Individual		\$6,600	\$6,600	\$6,600	\$6,600	\$8,550	\$8,550
Family		\$13,200	\$13,200	\$13,200	\$13,200	\$17,100	\$17,100
Office Visit							
Primary Physician		\$25.00	\$30.00	\$25.00	\$30.00	\$30.00	\$40.00
Specialist		\$35.00	\$40.00	\$35.00	\$40.00	\$45.00	\$55.00
Chiropractic		\$35.00	\$40.00	\$35.00	\$40.00	\$45.00	\$55.00
Urgent Care		\$35.00	\$50.00	\$35.00	\$50.00	\$75.00	\$75.00
Hospital Services							
In-Patient Admission		Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin
Surgical Services		Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin
Emergency Room		\$150.00 after Ded	\$150.00 after Ded	\$150.00 after Ded	\$150.00 after Ded	\$150.00 after Ded	\$150.00 after Ded
Imaging Services(X-Ray)		Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin
Advanced Imaging Services (Cat Scan/Pet Scan/MRI)		\$150.00 after Ded	\$150.00 after Ded	\$150.00 after Ded	\$150.00 after Ded	\$150.00 after Ded	\$150.00 after Ded
Laboratory		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Ambulance		Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	\$150.00 after Ded	\$150.00 after Ded
Prescription Drugs							
Generic		\$4.00 / \$15.00	\$6.00 / \$25.00	\$4.00 / \$15.00	\$6.00 / \$25.00	\$15.00	\$15.00
Preferred Brand		\$40.00	\$50.00	\$40.00	\$50.00	\$50.00	\$50.00
Non-Preferred Brand		\$80.00	\$80.00	\$80.00	\$80.00	\$80.00	\$80.00
Preferred Specialty		20% \$200.00	20% \$200.00	20% \$200.00	20% \$200.00	\$50.00	\$50.00
Non-Preferred Specialty		20% \$300.00	20% \$300.00	20% \$300.00	20% \$300.00	\$80.00	\$80.00
Contraceptives		included	included	included	included	included	included
Mail Order		3 co-pays less \$10.00	3 co-pays less \$10.00	3 co-pays less \$10.00	3 co-pays less \$10.00	2.5 co-pays	2.5 co-pays
Pediatric Dental & Vision		not included	not included	not included	not included	not included	not included
Dependent Eligibility							
Dependents Eligible end of year at Age		26	26	26	26	26	26
Participation requirement		minimum of 2 contracts		minimum of 2 contracts		minimum of 2 contracts	
Rate Guarantee				1 year		1 year	

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True Out of Pocket Annual Maximum(TROOP) includes Deductible, Coinsurance, Pharmacy and any services requiring a co-payment



Medical & Prescription Drug Cost Analysis

		Current BCN HBL HMO		Renewal BCN HBL HMO		Option 1 HAP HMO		Option 2 HAP HMO	
Count		Monthly Rates		Monthly Rates		Monthly Rates		Monthly Rates	
Single	9	\$435.30		\$446.44		\$438.28		\$443.46	
Two Person	7	\$1,044.72		\$1,071.46		\$1,051.87		\$1,064.30	
Family	17	\$1,305.89		\$1,339.32		\$1,314.84		\$1,330.38	
Estimated Monthly Premium		\$33,430.87		\$34,286.62		\$33,659.89		\$34,057.70	
Estimated Annual Premium		\$401,170.44		\$411,439.44		\$403,918.68		\$408,692.40	
Dollar Change		-		\$10,269.00		\$2,748.24		\$7,521.96	
Percent Change		-		2.56%		0.69%		1.88%	
Deductible		Enhanced	Standard	Enhanced	Standard	In-Network		In-Network	
Individual		\$1,000	\$3,000	\$1,000	\$3,000	\$1,000		\$1,200	
Family		\$2,000	\$6,000	\$2,000	\$6,000	\$2,000		\$2,400	
Coinsurance									
Individual		80%	70%	80%	70%	80%		80%	
Family		80%	70%	80%	70%	80%		80%	
Coinsurance Annual Maximum									
Individual		\$2,000	\$3,000	\$2,000	\$3,000	\$2,500		\$2,500	
Family		\$4,000	\$6,000	\$4,000	\$6,000	\$5,000		\$5,000	
True Out of Pocket Annual Maximum (TROOP)									
Individual		\$6,600	\$6,600	\$6,600	\$6,600	\$6,350		\$6,600	
Family		\$13,200	\$13,200	\$13,200	\$13,200	\$12,700		\$13,200	
Office Visit									
Primary Physician		\$25.00	\$30.00	\$25.00	\$30.00	\$20.00		\$20.00	
Specialist		\$35.00	\$40.00	\$35.00	\$40.00	\$40.00		\$40.00	
Chiropractic		\$35.00	\$40.00	\$35.00	\$40.00	\$40.00		\$40.00	
Urgent Care		\$35.00	\$50.00	\$35.00	\$50.00	\$75.00		\$75.00	
Hospital Services									
In-Patient Admission		Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin		Ded+Coin	
Surgical Services		Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin		Ded+Coin	
Emergency Room		\$150.00 after Ded	\$150.00 after Ded	\$150.00 after Ded	\$150.00 after Ded	\$250.00		\$250.00	
Imaging Services(X-Ray)		Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin		Ded+Coin	
Advanced Imaging Services (Cat Scan/Pet Scan/MRI)		\$150.00 after Ded	\$150.00 after Ded	\$150.00 after Ded	\$150.00 after Ded	Ded+Coin		Ded+Coin	
Laboratory		\$0.00	\$0.00	\$0.00	\$0.00	Ded+Coin		Ded+Coin	
Ambulance		Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin		Ded+Coin	
Prescription Drugs									
Generic		\$4.00 / \$15.00	\$6.00 / \$25.00	\$4.00 / \$15.00	\$6.00 / \$25.00	\$10.00 / \$20.00		\$7.00 / \$20.00	
Preferred Brand		\$40.00	\$50.00	\$40.00	\$50.00	\$40.00		\$30.00	
Non-Preferred Brand		\$80.00	\$80.00	\$80.00	\$80.00	\$80.00		\$60.00	
Preferred Specialty		20% \$200.00	20% \$200.00	20% \$200.00	20% \$200.00	30% \$200		30% \$200	
Non-Preferred Specialty		20% \$300.00	20% \$300.00	20% \$300.00	20% \$300.00	50% \$200		50% \$200	
Contraceptives		included	included	included	included	included		included	
Mail Order		3 co-pays less \$10.00	3 co-pays less \$10.00	3 co-pays less \$10.00	3 co-pays less \$10.00	2 co-pays		2 co-pays	
Pediatric Dental & Vision		not included	not included	not included	not included	not included		not included	
Dependent Eligibility									
Dependents Eligible end of year at Age		26	26	26	26	26		26	
Participation requirement		minimum of 2 contracts		minimum of 2 contracts		minimum of 2 contracts		minimum of 2 contracts	
Rate Guarantee				1 year		1 year		1 year	

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True Out of Pocket Annual Maximum(TROOP) includes Deductible, Coinsurance, Pharmacy and any services requiring a co-payment



Medical & Prescription Drug Cost Analysis

		Current BCN HBL HMO		Renewal BCN HBL HMO		Option 1 UHC Choice Plus	Option 2 UHC - H.S.A. Choice Plus
Count		Monthly Rates		Monthly Rates		Monthly Rates	Monthly Rates
Single	9	\$435.30		\$446.44		\$459.96	\$504.63
Two Person	7	\$1,044.72		\$1,071.46		\$1,103.90	\$1,203.91
Family	17	\$1,305.89		\$1,339.32		\$1,379.87	\$1,504.88
Estimated Monthly Premium		\$33,430.87		\$34,286.62		\$35,324.73	\$38,552.00
Estimated Annual Premium		\$401,170.44		\$411,439.44		\$423,896.76	\$462,624.00
Dollar Change		-		\$10,269.00		\$22,726.32	\$61,453.56
Percent Change		-		2.56%		5.67%	15.32%
Deductible		Enhanced	Standard	Enhanced	Standard	In-Network	In-Network
Individual		\$1,000	\$3,000	\$1,000	\$3,000	\$1,000	\$1,500
Family		\$2,000	\$6,000	\$2,000	\$6,000	\$2,000	\$3,000
Coinsurance							
Individual		80%	70%	80%	70%	80%	100%
Family		80%	70%	80%	70%	80%	100%
Coinsurance Annual Maximum							
Individual		\$2,000	\$3,000	\$2,000	\$3,000	\$2,500	N/A
Family		\$4,000	\$6,000	\$4,000	\$6,000	\$5,000	N/A
True Out of Pocket Annual Maximum (TROOP)							
Individual		\$6,600	\$6,600	\$6,600	\$6,600	\$7,150	\$2,500
Family		\$13,200	\$13,200	\$13,200	\$13,200	\$14,300	\$5,000
Office Visit							
Primary Physician		\$25.00	\$30.00	\$25.00	\$30.00	\$10.00 / \$10.00	Ded
Specialist		\$35.00	\$40.00	\$35.00	\$40.00	\$40.00 / \$80.00	Ded
Chiropractic		\$35.00	\$40.00	\$35.00	\$40.00	\$10.00 / \$10.00	Ded
Urgent Care		\$35.00	\$50.00	\$35.00	\$50.00	\$25.00	Ded
Hospital Services							
In-Patient Admission		Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded
Surgical Services		Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded
Emergency Room		\$150.00 after Ded	\$150.00 after Ded	\$150.00 after Ded	\$150.00 after Ded	\$300.00 + Ded	Ded
Imaging Services(X-Ray)		Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded
Advanced Imaging Services (Cat Scan/Pet Scan/MRI)		\$150.00 after Ded	\$150.00 after Ded	\$150.00 after Ded	\$150.00 after Ded	\$500.00	Ded
Laboratory		\$0.00	\$0.00	\$0.00	\$0.00	\$40.00	Ded
Ambulance		Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded+Coin	Ded
Prescription Drugs							*Co-pays after ded
Generic		\$4.00 / \$15.00	\$6.00 / \$25.00	\$4.00 / \$15.00	\$6.00 / \$25.00	\$5.00	\$5.00
Preferred Brand		\$40.00	\$50.00	\$40.00	\$50.00	\$40.00	\$40.00
Non-Preferred Brand		\$80.00	\$80.00	\$80.00	\$80.00	\$105.00	\$105.00
Preferred Specialty		20% \$200.00	20% \$200.00	20% \$200.00	20% \$200.00	\$250.00	\$250.00
Non-Preferred Specialty		20% \$300.00	20% \$300.00	20% \$300.00	20% \$300.00	\$250.00	\$250.00
Contraceptives		included	included	included	included	included	included
Mail Order		3 co-pays less \$10.00	3 co-pays less \$10.00	3 co-pays less \$10.00	3 co-pays less \$10.00	2.5 co-pays	2.5 co-pays
Pediatric Dental & Vision		not included	not included	not included	not included	not included	not included
Dependent Eligibility							
Dependents Eligible end of year at Age		26	26	26	26	26	26
Participation requirement		minimum of 2 contracts		minimum of 2 contracts		minimum of 2 contracts	minimum of 2 contracts
Rate Guarantee				1 year		1 year	1 year

Above rates are not a contractual agreement and any change in assumptions and/or group demographics could affect rates. Benefit descriptions above are for comparison only; plan document will govern. Group will not be bound by any typographical errors contained in this presentation.

True Out of Pocket Annual Maximum(TROOP) includes Deductible, Coinsurance, Pharmacy and any services requiring a co-payment