

GROUP BENEFITS

Highlights of Proposed Changes

Puget Sound

November 29, 2011

DENTAL BENEFITS

Dental plan options will be revised as follows:

	Current Dental Plans	Proposed Dental Plans
Puget Sound	<ul style="list-style-type: none"> - Incentive Dental Plan - Prepaid Dental Plan 	<ul style="list-style-type: none"> - Network Dental Plan - Prepaid Dental Plan

The Company will revise the dental plan benefits as described below effective July 1, 2012.

Coverage	Current		Proposed	
Dental Plan	Incentive Dental		Network Dental Plan	
	Network and Nonnetwork		Network	Nonnetwork
<i>Annual Deductible</i>	\$25/Individual; \$75/Family 3 or more; Annual deductible does not apply to exams, X-rays, cleanings	See Network Provisions	\$50/individual, \$150/family, doesn't apply to preventive care or orthodontia	\$75/Individual, \$225/family, applies to all covered services except orthodontia
<i>Annual maximum coverage per person</i>	\$1,750; for all covered services except orthodontia	See Network Provisions	\$2,000/individual, for all covered services except orthodontia, network-nonnetwork combined	See network provisions
<i>Diagnostic and Preventive care (Class I)</i>	Class I (preventive limited minor restoration): 70% to 90% of covered charges based on benefit use during consecutive annual incentive periods; Prophylaxis (cleaning), either regular or periodontal, once in a four-month period, Full mouth/panographic x-ray once in consecutive 36 mo period, Fluoride treatment (to age 18), Fissure sealants (to age 13) Specialty Consults not covered	See Network Provisions	100% covered; deductible doesn't apply - Cleanings twice in a one-year period; two additional cleanings if periodontal disease present - Full-mouth x-ray once in a five year period. - Fluoride treatment twice in a one year period - Specialist exams up to 3 exams in a six-month period	80% of recognized fee after deductible is met - Cleanings twice in a one-year period; two additional cleanings if periodontal disease present - Full-mouth x-ray once in a five year period. - Fluoride treatment twice in a one year period - Specialist exams up to 3 exams in a six-month period

<i>Basic services (Class II)</i>	Class II 70% of covered charges	See Network Provisions	80% of recognized fee after deductible is met	50% of recognized fee after deductible is met
<i>Major services (Class III)</i>	Class III (prosthodontics): 50% covered after deductible is met	See Network Provisions	60% of recognized fee after deductible is met	50% of recognized fee, after deductible is met
<i>Orthodontia services (Class IV)</i>	Class IV: 50% covered; \$2,000 lifetime maximum/individual, deductible doesn't apply, network-nonnetwork combined, Class IV payment level	See Network Provisions	No change	No change
<i>Provider choice</i>	Use any dentist and receive coverage at specified payment levels. Your dentist decides which treatment plan to follow. The Incentive Dental Plan covers the least expensive method of treatment that meets generally accepted dental care standards	See Network Provisions	Use any network dentist to receive highest payment levels; orthodontia care can be received from any licensed dentist	Use any nonnetwork dentist and receive lower payment levels; orthodontia care can be received from any licensed dentist

ACTIVE EMPLOYEE MEDICAL PLAN OFFERINGS

The Company will revise medical plan benefits as described below effective January 1, 2013. Increases to the contact lenses allowance and frame allowance will be effective July 1, 2012.

	Selections CCP - Washington		Selections CCP - Washington	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<i>Deductible</i>	Not applicable	\$400/individual	Not applicable	\$450/individual
<i>Annual Out-of-Pocket</i>	Not applicable	\$2,000/individual, \$4,000/family	Not applicable	\$2,250/individual, \$4,500 /family
<i>Emergency Room</i>	\$50 copay, copay waived if admitted, non-emergent care covered at 60% after copay	See network provisions	\$75 copay, copay waived if admitted, non-emergent care covered at 60% after copay	See network provisions
<i>Office visit</i>	\$10 copay	60% covered after deductible is met	\$15copay	60% covered after deductible is met
Prescription Drug Expenses				
<i>Retail Generic</i>	\$5 copay, 34 day supply	Not covered	\$5 copay, 30 day supply	Not covered
<i>Retail Brand-formulary</i>	\$15 copay, 34 day supply	Not covered	\$20 copay, 30 day supply, if generic equivalent available, member pays cost difference between brand and generic plus generic copay	Not covered

<i>Retail Brand-nonformulary</i>	\$30 copay, 34 day supply	Not covered	\$35 copay, 30 day supply, if generic equivalent available, member pays cost difference between brand and generic plus generic copay	Not covered
<i>Mail Order Brand-formulary</i>	\$30 copay, 90 day supply	Not covered	\$40 copay, 90 day supply, if generic equivalent available, member pays cost difference between brand and generic plus generic copay	Not covered
<i>Mail Order Brand - nonformulary</i>	\$60 copay, 90 day supply	Not covered	\$70 copay, 90 day supply, if generic equivalent available, member pays cost difference between brand and generic plus generic copay	Not covered
Vision Care				
<i>Routine vision exams</i>	\$10 copay, 1 exam per benefit year	Not covered	\$15 copay for routine exam, 1 exam per benefit year	Not covered
<i>Regular lenses and frames</i>	\$50-\$155 allowance for lenses, \$70 allowance for frames, 2 pairs every 2 benefit years, network-nonnetwork combined	See network provisions	\$50-\$155 allowance for 2 lenses, \$90 allowance for frames, 2 pairs every 2 benefit years, network-nonnetwork combined	See network provisions
<i>Contact lenses</i>	\$105 allowance for contact lenses, 2 pairs every 2 benefit years, network-nonnetwork combined	See network provisions	\$120 allowance for contact lenses, 2 pairs every 2 benefit years, network-nonnetwork combined	See network provisions
	Group Health HMO		Group Health HMO	
	In-Network	Out-of-Network	In-Network	Out-of-Network No coverage except emergency treatment
<i>Emergency Room</i>	\$50 copay, copay waived if admitted	\$100 copay, copay waived if admitted	\$75 copay, copay waived if admitted	\$75 copay, copay waived if admitted
<i>Office visit</i>	\$10 copay	Not covered	\$15 copay	Not covered
Prescription Drug Expenses				
<i>Retail Brand-formulary</i>	\$15 copay, 30 day supply,	Not covered	\$20 copay, 30 day supply, Member Pay the Difference provisions may apply	Not covered
<i>Mail Order Brand-formulary</i>	\$30 copay, 90 day supply	Not covered	\$40 copay, 90 day supply, Member Pay the Difference provisions may apply	Not covered
Vision Care				
<i>Routine vision exams</i>	\$10 copay, 1 exam per 12 months	Not covered	\$15 copay, 1 exam per 12 months	Not covered

	Traditional Medical Plan		Traditional Medical Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<i>Plan Year Deductibles</i>	\$200/individual, \$600/family, network-nonnetwork combined	See network provisions	\$225/individual, \$675/family, network-nonnetwork combined	See network provisions
<i>Coinsurance</i>	100%/95% after deductible is met	60% covered after deductible is met	90% covered after deductible is met	60% covered after deductible is met
<i>Annual out-of-pocket maximum per person</i>	\$2,000/individual, \$4,000/family, network-nonnetwork combined	See network provisions	\$2,000/individual, \$4,500/family, network-nonnetwork combined	See network provisions
<i>Emergency room (not followed by admission); must meet the definition of Emergency, determined by service provider</i>	\$50 copay, then 95% covered after deductible is met, 100% after copay if hospital meets patient safety standards, copay waived if admitted, non-emergent care covered at 95% after deductible and copay	\$50 copay, then 95% covered after deductible is met, copay waived if admitted, non-emergent care covered at 60% after deductible and copay	\$75 copay, then 90% covered after deductible is met, copay waived if admitted, non-emergent care covered at 90% after deductible and copay	\$75 copay, then 90% covered after deductible is met, copay waived if admitted, non-emergent care covered at 60% after deductible and copay
PREVENTIVE CARE				
<i>Well child (including immunizations)</i>	100% covered, 1 exam/year age 2-5, immunizations covered in accordance with prescribed guidelines and as recommended by doctor	Not covered	100% covered, 1 exam/year age 2-18, immunizations covered in accordance with prescribed guidelines and as recommended by doctor Frequency exceptions in accordance with established guidelines	Not covered
<i>Hearing evaluation</i>	\$15 copay, 95% covered after deductible is met for hearing test, allowed only if disease present	60% covered after deductible is met, allowed only if disease is present	100% covered according to prescribed guidelines for preventive hearing screening, \$15 copay if disease is present or for other services	60% covered after deductible is met, allowed only if disease is present
<i>Hearing aids</i>	95% covered after deductible is met, \$600 allowance/ear every 3 benefit years, network-nonnetwork combined	60% covered after deductible is met, \$600 allowance/ear every 3 benefit years, network-nonnetwork combined	90% covered after deductible is met, \$800 allowance/ear, every 3 benefit years, network-nonnetwork combined	60% covered after deductible is met, \$800 allowance/ear every 3 benefit years, network-nonnetwork combined
Centers of Excellence	No specific provision for Centers of Excellence		100% for plan identified Centers of Excellence for specified transplants and bariatric surgery plus specified travel expenses	
PRESCRIPTION DRUG				
<i>Retail Generic</i>	\$5 copay, greater of a 34-day supply or 100 units per prescription	See network provisions	\$5 copay, 30 day supply	See network provisions
<i>Retail Brand-formulary</i>	\$15 copay, greater of a 34-day supply or 100 units per prescription	See network provisions	\$20 copay, 30 day supply	See network provisions
<i>Retail Brand-nonformulary</i>	\$30 copay, greater of a 34-day supply or 100 units per prescription	See network provisions	\$35 copay, 30 day supply	See network provisions

<i>Mail Order Brand-formulary</i>	\$30 copay, 90 day supply	Not covered	\$40 copay, 90 day supply, if generic equivalent available, member pays cost difference between brand and generic plus generic copay	Not covered
<i>Mail Order Brand - nonformulary</i>	\$60 copay, 90 day supply	Not covered	\$70 copay, 90 day supply, if generic equivalent available, member pays cost difference between brand and generic plus generic copay	Not covered
VISION				
<i>Regular lenses and frames</i>	\$50-\$155 allowance for 2 lenses, \$70 allowance for frames, 2 pairs every 2 benefit years, network-nonnetwork combined	See network provisions	\$50-\$155 allowance for 2 lenses, \$90 allowance for frames, 2 pairs every 2 benefit years, network-nonnetwork combined	See network provisions
<i>Contact lenses (in place of allowance for conventional lenses and frames)</i>	\$105 allowance for contact lenses in lieu of lenses and frames, network-nonnetwork combined	See network provisions	\$120 allowance for contact lenses in lieu of lenses and frames, network-nonnetwork combined	See network provisions
Coverage	Current	Proposed		
Pharmacy Management		<ul style="list-style-type: none"> - Member Pay the Difference (MPD) - Step Therapy (process whereby member is asked to try a preferred drug when multiple drugs are available for the same condition; when member is using different drug, advance notice to physician and opportunity to request review is provided) 		
Flexible Spending Accounts Health Care and Dependent Care	Health Care Spending Account: Not offered Dependent Care Spending Account: Employees may contribute, between \$250 and \$5,000, on a pretax basis.	Health Care Spending Account: Employees may contribute, between \$250 and \$2,500, on a pretax basis Dependent Care Spending Account: No Change		

EMPLOYEE CONTRIBUTIONS

Monthly Active Employee Contributions

Contribution rates shown are Employee only rates

Employee+Spouse or Employee+Child(ren) are 2 times the Employee only rate

Employee+Family are 3 times the employee only rate

Beginning January 1, 2013, active employee medical plan contributions will be as follows:

Washington			
	Traditional Medical Plan	Selections CCP	Group Health HMO
Contribution	\$20	\$45	\$45

Beginning January 1, 2014, contributions for all plans will increase ten percent (10%) each year.

Active Employee Medical Plan Contributions				
	2013	2014	2015	2016
Employee only rate	\$20.00	\$22.00	\$24.20	\$26.62
Employee only rate	\$45.00	\$49.50	\$54.45	\$59.90

The additional \$100 monthly working spouse contribution will continue to apply to all plans.

Beginning January 1, 2013, there will be an additional contribution each calendar year as follows for employees and spouses who do not complete certain health improvement activities. For 2013, those health improvement activities will consist of completing the online health assessment. The additional contributions will be as follows:

- For *either* employee-only coverage *or* employee + child(ren) coverage, the additional contribution will be \$20 per month if the employee does not complete the online assessment.
- For *either* employee + spouse coverage *or* employee + spouse and child(ren) coverage, the additional contribution will be \$40 per month if both the employee and spouse do not complete the health assessment *or* \$20 per month if only the employee *or* spouse completes the online assessment.

In the event Federal government guidance restricts or limits the application of these provisions concerning health improvement activities, they will be adjusted accordingly. The Company continues to bear the vast majority of employee health care costs; however, the parties recognize the potential that excise taxes may be levied on the health care benefits as mandated by federal or state legislation. The potential for such taxes, and actions the parties can take to avoid such taxes will be discussed with the Joint Committee on Health Care, Cost and Quality.