SEMI-MONTHLY MEDICAL RATES, SELF-FUNDED & GROUP HEALTH

2017 Premiums Per Pay Period (effective 01/01/2017)

APPLIES TO : All Regular Employees

SELF-FUNDED MEDICAL & Rx ONLY

	Full Premium	City Pays	Full time Employee Pays	*FTE 30-34.99* (25%)*	*FTE 25-29.99* (37.5%)*	*FTE 20-24.99* (50%)*
Employee LEOFF I	$307.13	$307.13	**$0.00**	NA	NA	NA
Employee	$307.13	$282.56	**$24.57**	$76.78	$115.17	$153.57
Employee, Child	$508.86	$468.15	**$40.71**	$278.51	$316.90	$355.29
Employee, Two Children	$665.61	$612.36	**$53.25**	$435.26	$473.65	$512.04
Employee, Spouse	$702.68	$646.46	**$56.21**	$472.33	$510.72	$549.11
Employee, Spouse, Child	$904.39	$832.04	**$72.35**	$674.04	$712.43	$750.83
Family Rate *(includes employee, spouse, and two or more children)*	$1,061.15	$976.25	**$84.89**	$830.80	$869.19	$907.58

GROUP HEALTH COOPERATIVE (includes Vision)

	Full Premium	City Pays	Full time Employee Pays	FTE Hired Before 11/2004**	*FTE 30-34.99* (25%)*	*FTE 25-29.99* (37.5%)*	*FTE 20-24.99* (50%)*
Employee LEOFF I	$465.93	$465.93	**N/A**	**$0.00**	N/A	N/A	N/A
Employee	$384.54	$359.50	**$96.58**	**$25.04**	$96.14	$144.20	$192.27
Employee, Child	$665.37	$623.88	**$188.27**	**$41.49**	$376.97	$425.03	$473.10
Employee, Two Children	$910.65	$856.38	**$286.58**	**$54.27**	$622.25	$670.31	$718.38
Employee, Spouse	$970.51	$913.22	**$311.68**	**$57.29**	$682.11	$730.17	$778.24
Employee, Spouse, Child	$1,251.32	$1,177.58	**$403.37**	**$73.74**	$962.92	$1,010.98	$1,059.05
Family Rate *(includes employee, spouse, and two or more children)*	$1,496.59	$1,410.07	**$501.66**	**$86.52**	$1,208.19	$1,256.25	$1,304.32

**** Part-time employees can elect to pay a pro-rated portion of the full premium for themselves ONLY. The dollar amount they pay for the medical package and/or dental package is based on the number of hours worked, as indicated above. The percentage of the total premium they pay for themselves is listed in the parentheses. They must pay the full premium for any dependent coverage. (This is reflected in the rates listed above).***

***** Group Health Cooperative: Employees hired after November 1, 2004, must pay the employee share listed above as well as the difference between the full premiums for Group Health and the Self-Funded medical plan (see total costs in the "Full time Employee Pays" column).***

SEMI-MONTHLY DENTAL & VISION, DENTAL ONLY (GH) RATES

2017 Premiums Per Pay Period (effective 01/01/2017)

APPLIES TO : All Regular Employees

SELF-FUNDED DENTAL & VISION

	Full Premium	City Pays	Full time Employee Pays	*30-34.99* (25%)*	*25-29.99* (37.5%)*	*20-24.99* (50%)*
Employee	$37.42	$34.42	$2.99	$9.35	$14.03	$18.71
Employee, Child	$71.43	$65.71	$5.71	$43.36	$48.04	$52.72
Employee, Two Children	$102.73	$94.51	$8.22	$74.67	$79.35	$84.02
Employee, Spouse	$79.75	$73.37	$6.38	$51.69	$56.37	$61.04
Employee, Spouse, Child	$113.77	$104.67	$9.10	$85.71	$90.39	$95.06
Family Rate *(includes employee, spouse, and two or more children)*	$145.08	$133.47	$11.61	$117.01	$121.69	$126.37

HMA DENTAL ONLY (GROUP HEALTH)

	Full Premium	City Pays	Full time Employee Pays	*30-34.99* (25%)*	*25-29.99* (37.5%)*	*20-24.99* (50%)*
Employee	$31.54	$29.02	$2.52	$7.89	$11.83	$15.77
Employee, Child	$61.70	$56.76	$4.94	$38.04	$41.98	$45.93
Employee, Two Children	$90.00	$82.80	$7.20	$66.35	$70.29	$74.23
Employee, Spouse	$66.31	$61.01	$5.30	$42.66	$46.60	$50.54
Employee, Spouse, Child	$96.48	$88.76	$7.72	$72.82	$76.76	$80.71
Family Rate *(includes employee, spouse, and two or more children)*	$124.78	$114.79	$9.98	$101.12	$105.06	$109.01