ATTACHMENT A-1
BLUE SHIELD HEALTH PLAN MONTHLY PREMIUM RATES
ALL ACTIVE EMPLOYEES
Effective January 1, 2010 through December 31, 2010 (12 months)
Monthly rate excludes the EAP & Care Counsel cost

BLUE SHIELD HEALTH PLANS*	Monthly Rates
Medical Plans	Blue Shield
Aetna HMO Low to Blue Shield EPO Low	
Employee Only	$408.68
Employee + 1 Dependent	$756.06
Employee + 2 or More Dependents	$1,187.18
Aetna HMO High to Blue Shield EPO High	
Employee Only	$470.61
Employee + 1 Dependent	$870.63
Employee + 2 or More Dependents	$1,367.07
PPO	
Employee Only	$627.77
Employee + 1 Dependent	$1,161.37
Employee + 2 or More Dependents	$1,825.75
PPO - HIGH DEDUCTIBLE	
Employee Only	$345.01
Employee + 1 Dependent	$618.27
Employee + 2 or More Dependents	$973.41

* All medical plans include domestic partner coverage not listed here.

ATTACHMENT A-2
2010 MEDICAL INSURANCE PREMIUMS
Twice-Monthly Premium Schedule
Effective January 1, 2010 through December 31, 2010

Twice monthly premiums for medical plans include $2.33 for Employee Assistance Plans

MEDICAL PLANS

BLUE SHIELD EPO LOW OPTION $25 Office Visit Copay $500 + 20% Hospital Copay (after deductable)	Medical Premium	County Contribution	Pre-Tax Employee Cost	After-Tax Employee Cost
Employee Only	206.67	-206.67	0.00	
with 1 Dependent	380.36	-206.67	173.69	
with 2 or More Dependents	595.92	-206.67	389.25	
Employee + Domestic Partner	380.36	-206.67	0.00	173.69
with 1 Dependent	595.92	-206.67	173.69	215.56
with 2 or More Dependents	595.92	-206.67	389.25	
with 1 or More DP Dependents	595.92	-206.67		389.25
with 1 Dependent & 1 or More DP Dependents	595.92	-206.67	173.69	215.56

BLUE SHIELD EPO HIGH OPTION $20 Office Visit Copay $250 + 20% Hospital Copay (no deductible)	Medical Premium	County Contribution	Pre-Tax Employee Cost	After-Tax Employee Cost
Employee Only	237.64	-206.67	30.97	
with 1 Dependent	437.65	-206.67	230.98	
with 2 or More Dependents	685.87	-206.67	479.20	
Employee + Domestic Partner	437.65	-206.67	30.97	200.01
with 1 Dependent	685.87	-206.67	230.98	248.22
with 2 or More Dependents	685.87	-206.67	479.20	
with 1 or More DP Dependents	685.87	-206.67		479.20
with 1 Dependent & 1 or More DP Dependents	685.87	-206.67	230.98	248.22

BLUE SHIELD PPO	Medical Premium	County Contribution	Pre-Tax Employee Cost	After-Tax Employee Cost
Employee Only	316.22	-206.67	109.55	
with 1 Dependent	583.02	-206.67	376.35	
with 2 or More Dependents	915.21	-206.67	708.54	
Employee + Domestic Partner	583.02	-206.67	109.55	266.80
with 1 Dependent	915.21	-206.67	376.35	332.19
with 2 or More Dependents	915.21	-206.67	708.54	
with 1 or More DP Dependents	915.21	-206.67		708.54
with 1 Dependent & 1 or More DP Dependents	915.21	-206.67	376.35	332.19

BLUE SHIELD HDHP HIGH DEDUCTIBLE HEALTH PLAN - PPO ($900 per year County Contribution to Employee's Health Savings Account)	Medical Premium	County Contribution (excl.HSA Contrib)	Pre-Tax Employee Cost	After-Tax Employee Cost
Employee Only	174.84	-174.84	0.00	
with 1 Dependent	311.47	-174.84	136.63	
with 2 or More Dependents	489.04	-174.84	314.20	
Employee + Domestic Partner	311.47	-174.84	0.00	136.63
with 1 Dependent	489.04	-174.84	136.63	177.57
with 2 or More Dependents	489.04	-174.84	314.20	
with 1 or More DP Dependents	489.04	-174.84		314.20
with 1 Dependent & 1 or More DP Dependents	489.04	-174.84	136.63	177.57

ATTACHMENT A-3 BLUE SHIELD RETIREE MONTHLY PREMIUM RATES Effective January 1, 2010 through December 31, 2010	
EARLY RETIREES (Pre-65)	
Medical Plans	Blue Shield
LOW OPTION EPO	
Retiree w/o MC	$787.09
Retiree + 1 Dep, both w/o MC	$1,456.12
Retiree + 2 Deps, all w/o MC	$2,286.42
HIGH OPTION EPO	
Retiree w/o MC	$906.36
Retiree + 1 Dep, both w/o MC	$1,676.78
Retiree + 2 Deps, all w/o MC	$2,632.88
PPO	
Retiree w/o MC	$806.88
Retiree + 1 Dep, both w/o MC	$1,492.73
Retiree + 2 Deps, all w/o MC	$2,346.68
OUT-OF-AREA PLAN PPO, includes in- and out-of-state PPO retirees	
Retiree w/o MC	$806.88
Retiree + 1 Dep, both w/o MC	$1,492.73
Retiree + 2 Deps, all w/o MC	$2,346.68
HDHP - HIGH DEDUCTIBLE HEALTH PLAN	
Retiree w/o MC	$595.42
Retiree + 1 Dep, both w/o MC	$1,101.53
Retiree + 2 Deps, all w/o MC	$1,731.69

ATTACHMENT A-4
BLUE SHIELD RETIREE MONTHLY PREMIUM RATES
Effective January 1, 2010 through December 31, 2010

POST- 65 RETIREES	Monthly Rates		
Medical Plans	Aetna	Blue Shield	$ change
LOW OPTION EPO			
Retiree w/ MC	$ 256.20	$ 421.00	$ 164.80
Retiree w/o MC	$ 619.10	$ 787.09	$ 167.99
Retiree + 1 Dep, both w/ MC	$ 512.40	$ 842.00	$ 329.60
Retiree + 1 Dep, both w/o MC	$ 1,151.99	$ 1,456.12	$ 304.13
Retiree w/o MC + 1 Dep, w/ MC	$ 875.30	$ 787.09	$ (88.21)
Retiree w/ MC + 1 Dep, w/o MC	$ 875.30	$ 669.03	$ (206.27)
Retiree + 2 Deps, all w/o MC	$ 1,795.47	$ 2,286.42	$ 490.95
Retiree w/ MC + 2 Deps w/o MC	$ 1,408.19	$ 1,499.33	$ 91.14
HIGH OPTION EPO			
Retiree w/ MC	$ 403.30	$ 431.57	$ 28.27
Retiree w/o MC	$ 917.82	$ 906.36	$ (11.46)
Retiree + 1 Dep, both w/ MC	$ 806.60	$ 863.15	$ 56.55
Retiree + 1 Dep, both w/o MC	$ 1,704.37	$ 1,676.78	$ (27.59)
Retiree w/o MC + 1 Dep, w/ MC	$ 1,321.12	$ 1,337.93	$ 16.81
Retiree w/ MC + 1 Dep, w/o MC	$ 1,321.12	$ 1,201.99	$ (119.13)
Retiree + 2 Deps, all w/o MC	$ 2,665.79	$ 2,632.88	$ (32.91)
Retiree w/ MC + 2 Deps w/o MC	$ 2,107.67	$ 2,158.09	$ 50.42
PPO			
Retiree w/ MC	$ 422.98	$ 481.00	$ 58.02
Retiree w/o MC	$ 567.19	$ 806.88	$ 239.69
Retiree + 1 Dep, both w/ MC	$ 845.95	$ 962.00	$ 116.05
Retiree + 1 Dep, both w/o MC	$ 1,049.29	$ 1,492.73	$ 443.44
Retiree w/o MC + 1 Dep, w/ MC	$ 990.17	$ 1,287.88	$ 297.71
Retiree w/ MC + 1 Dep, w/o MC	$ 990.17	$ 1,166.85	$ 176.68
Retiree + 2 Deps, all w/o MC	$ 1,644.86	$ 2,346.68	$ 701.82
Retiree w/ MC + 2 Deps w/o MC	$ 1,472.27	$ 2,020.80	$ 548.53
OUT-OF-AREA PLAN PPO, includes in- and out-of-state PPO retirees			
Retiree w/ MC	$ 441.61	$ 481.00	$ 39.39
Retiree w/o MC	$ 567.19	$ 806.88	$ 239.69
Retiree + 1 Dep, both w/ MC	$ 845.95	$ 962.00	$ 116.05
Retiree + 1 Dep, both w/o MC	$ 1,049.29	$ 1,492.73	$ 443.44
Retiree w/o MC + 1 Dep, w/ MC	$ 1,008.80	$ 1,287.88	$ 279.08
Retiree w/ MC + 1 Dep, w/o MC	$ 1,008.80	$ 1,166.85	$ 158.05
Retiree + 2 Deps, all w/o MC	$ 1,644.86	$ 2,346.68	$ 701.82
Retiree w/ MC + 2 Deps w/o MC	$ 1,490.90	$ 2,020.80	$ 529.90
HDHP - HIGH DEDUCTIBLE HEALTH PLAN			
Retiree w/ MC	$ 436.08	$ 481.00	$ 44.92
Retiree w/o MC	$ 454.42	$ 806.88	$ 352.46
Retiree + 1 Dep, both w/ MC	$ 890.50	$ 962.00	$ 71.50
Retiree + 1 Dep, both w/o MC	$ 845.01	$ 1,492.73	$ 647.72
Retiree w/o MC + 1 Dep, w/ MC	$ 890.50	$ 1,287.88	$ 397.38
Retiree w/ MC + 1 Dep, w/o MC	$ 890.50	$ 1,166.85	$ 276.35
Retiree + 2 Deps, all w/o MC	$ 1,316.86	$ 2,346.68	$ 1,029.82
Retiree w/ MC + 2 Deps w/o MC	$ 1,281.09	$ 2,020.80	$ 739.71

County of Santa Barbara
Custom EPO – Low Option
Benefit Summary (For groups of 300 and above)
(Uniform Health Plan Benefits and Coverage Matrix)

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Blue Shield of California

Effective January 1, 2010

DEDUCTIBLES[1] (All providers combined)	**Preferred Providers**[2]
Calendar year medical deductible	$200 per individual $400 per family
Calendar year Copayment Maximum[1]	$2,000 per individual $4,000 per family
LIFETIME MAXIMUM	Unlimited
Covered Services	**Member Copayment**
PROFESSIONAL SERVICES	**Preferred Providers**[2]
Professional (physician) benefits	
• Physician and specialist office visit	$25/visit[1]
• Diagnostic testing	No charge
• Outpatient X-ray, pathology and laboratory	No charge
Allergy testing and treatment benefits[11]	
• Office visits (includes visits for allergy serum injections)	$25/visit[1]
Preventive care benefits	
• Annual routine physical examination, vision and hearing screening and immunizations	No charge
• Routine laboratory services, including annual mammography, Papanicolaou test, or cervical cancer and human papillomavirus (HPV) screening (One per calendar year)	No charge
• Well baby care (Includes: eye/ear screenings, immunizations, vaccinations)	No charge
• Well baby laboratory	No charge
OUTPATIENT SERVICES	
Hospital benefits (facility services)	
• Outpatient surgery performed in a Participating Ambulatory Surgery Center (ASC)[3]	$500/surgery + 20%
• Outpatient surgery in a hospital	$500/surgery + 20%
• Outpatient services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation services")	No charge
• Bariatric surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity)[5]	$500/surgery + 20%
HOSPITALIZATION SERVICES	
Hospital benefits (facility services)	
• Inpatient physician benefits	No charge
• Semi-private room and board, medically necessary services and supplies	$500/admission + 20%
• Bariatric surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity)[5]	$500/admission + 20%
Skilled nursing facility benefits[6] (Combined maximum of up to 100 preauthorized days per calendar year; semi-private accommodations)	
• Skilled nursing free standing facility	20%
• Skilled nursing facility unit of a hospital	20%
EMERGENCY HEALTH COVERAGE	
• Emergency room services not resulting in admission (If ER services do not result in a direct admission)	$200/visit[1]
• Emergency room services resulting in admission (when the member is admitted directly from the ER)	$500/admission + 20%
• Emergency room physician services	No charge
AMBULANCE SERVICES	
• Emergency or authorized transport	$50[1]

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Benefit	Copayment
PROSTHETICS/ORTHOTICS	
• Prosthetic equipment and devices (Separate office visit copay may apply)	20%
• Orthotic equipment and devices (Separate office visit copay may apply)	20%
DURABLE MEDICAL EQUIPMENT	
• Durable medical equipment services	20%
Hearing Aid	
• Hearing Aid Instrument and ancillary equipment (Up to a maximum of $700 per member every 24 months for the hearing aid and ancillary equipment)	No charge
MENTAL HEALTH SERVICES (PSYCHIATRIC)[7]	
• Inpatient hospital facility services	$500/admission + 20%
• Outpatient mental health services	$25/visit[1]
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)[9]	
• Inpatient hospital facility services	$500/admission + 20%
• Outpatient chemical dependency services	$25/visit[1]
HOME HEALTH SERVICES[4]	
• Home health care agency services (Maximum of 100 prior authorized visits per calendar year)	20%
• Home infusion/Home injectable therapy provided by a home infusion agency	20%
OTHER	
Hospice program benefits[4]	
• Routine home care	No charge
• Inpatient respite care	No charge
• 24-hour continuous home care	20%
• General inpatient care	20%
Chiropractic benefits	
• Chiropractic services	Not covered
Acupuncture benefits	
• Acupuncture services	Not covered
Rehabilitation services (physical, occupational and respiratory therapy)	
• In an office location (Up to 26 visits per calendar year)	$25/visit[1]
Speech therapy benefits	
• In an office location (Speech therapy services by a licensed speech pathologist or certified speech therapist)	$25/visit[1]
Pregnancy and maternity care	
• Prenatal and postnatal physician office visits (For inpatient hospital services, see "Hospitalization Services.")	No charge
Family planning benefits	
• Counseling and consulting	$25/visit[1]
• Infertility services (Diagnosis and treatment of causes of infertility. Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT)	50% of allowed charges
• Elective abortion[8]	$100
• Tubal ligation[8]	$100
• Vasectomy[8]	$75
Diabetes care benefits	
• Devices, equipment, and non-testing supplies	20%
• Diabetes self-management training (If billed by your provider, you will also be responsible for the office visit copayment)	$25/visit[1]
Care Outside of Plan Service Area Benefits provided through BlueCard® Program, for out-of-state emergency and non-emergency care, are provided at the preferred level of the local Blue Plan allowable amount when you use a Blue Cross/Blue Shield provider.	
• Within US: BlueCard Program	See Applicable Benefit
• Outside of US: BlueCard Worldwide	See Applicable Benefit

1 Deductible and copayments marked with a (1) do not accrue to calendar-year copayment maximum. Copayments and charges for services not accruing to the member's calendar-year copayment maximum continue to be the member's responsibility after the calendar-year copayment maximum is reached. Deductible does not apply toward the calendar-year maximum. Please refer to the Plan Contract for exact terms and conditions of coverage.

2 Member is responsible for copayment in addition to any charges above allowable amounts. The copayment percentage indicated is a percentage of allowable amounts. Preferred providers accept Blue Shield's allowable amount as full payment for covered services. Non-preferred providers can charge more than these amounts. When members use non-preferred providers, they must pay the applicable copayment plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the calendar-year deductible or copayment maximum.

3 Participating ambulatory surgery centers may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital or an ambulatory surgery center affiliated with a hospital, with payment according to your health plan's hospital services benefits.
4 Out of network home health care, home infusion and hospice services are not covered unless pre-authorized. When these services are pre-authorized, the member pays the Preferred Provider copayment
5 Bariatric surgery is covered when pre-authorized by Blue Shield. However, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara and Ventura Counties ("Designated Counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons; coverage is not available for bariatric services from any other preferred provider and there is no coverage for bariatric services from non-preferred Providers. In addition, if prior authorized by Blue Shield of California, a member in a Designated County who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the Plan Contract for further benefit details.
6 Services may require prior authorization by Blue Shield. When these services are prior authorized, members pay the preferred or participating provider amount.
7 Mental health services are accessed through Blue Shield using Blue Shield's participating and non-participating providers. For a listing of severe mental illnesses, including serious emotional disturbances of a child, and other benefit details, please refer to the Plan Contract.
8 Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply.
9 Inpatient services for acute detoxification are covered under the medical benefit; see hospitalization services for benefit details. Services for medical acute detoxification are accessed through Blue Shield using Blue Shield's preferred providers or non-preferred providers.

Plan designs may be modified to ensure compliance with state and federal requirements

County of Santa Barbara
Custom EPO – High Option
Benefit Summary (For groups of 300 and above)
(Uniform Health Plan Benefits and Coverage Matrix)

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Blue Shield of California

Effective January 1, 2010

DEDUCTIBLES[1] (All providers combined)	**Preferred Providers**[2]
Calendar year medical deductible	$0 per individual $0 per family
Calendar year Copayment Maximum[1]	$1,500 per individual $3,000 per family
LIFETIME MAXIMUM	Unlimited
Covered Services	**Member Copayment**
PROFESSIONAL SERVICES	**Preferred Providers**[2]
Professional (physician) benefits	
• Physician and specialist office visits	$20/visit
• Diagnostic testing	No charge
• Outpatient X-ray, pathology and laboratory	No charge
Allergy testing and treatment benefits	
• Office visits (includes visits for allergy serum injections)	$20/visit[1]
Preventive care benefits	
• Annual routine physical examination, vision and hearing screening and immunizations	No charge
• Routine laboratory services, including annual mammography, Papanicolaou test, or cervical cancer and human papillomavirus (HPV) screening (One per calendar year)	No charge
• Well baby care (Includes: eye/ear screenings, immunizations, vaccinations)	No charge
• Well baby laboratory	No charge
OUTPATIENT SERVICES	
Hospital benefits (facility services)	
• Outpatient surgery performed in a Participating Ambulatory Surgery Center (ASC)[3]	No charge
• Outpatient surgery in a hospital	No charge
• Outpatient services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation services")	No charge
• Bariatric surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity)[6]	No charge
HOSPITALIZATION SERVICES	
Hospital benefits (facility services)	
• Inpatient physician benefits	No charge
• Semi-private room and board, medically necessary services and supplies	$250/admission + 20%
• Bariatric surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity)[6]	$250/admission + 20%
Skilled nursing facility benefits[6] (Combined maximum of up to 100 preauthorized days per calendar year; semi-private accommodations)	
• Skilled nursing free standing facility	20%
• Skilled nursing facility unit of a hospital	20%

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Benefit	Copayment
EMERGENCY HEALTH COVERAGE	
• Emergency room services not resulting in admission (If ER services do not result in a direct admission the Calendar-Year Deductible does not apply)	$100/visit[1]
• Emergency room services resulting in admission (when the member is admitted directly from the ER)	$250/admission + 20%
• Emergency room physician services	No charge
AMBULANCE SERVICES	
• Emergency or authorized transport	$50[1]
PROSTHETICS/ORTHOTICS	
• Prosthetic equipment and devices (Separate office visit copay may apply)	No charge
• Orthotic equipment and devices (Separate office visit copay may apply)	No charge
DURABLE MEDICAL EQUIPMENT	
• Durable medical equipment services	No charge
Hearing Aid	No charge
• Hearing Aid Instrument and ancillary equipment (Up to a maximum of $700 per member every 24 months for the hearing aid and ancillary equipment)	
MENTAL HEALTH SERVICES (PSYCHIATRIC)[7]	
• Inpatient hospital facility services	$250/admission + 20%
• Outpatient mental health services	$20/visit[1]
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)[10]	
• Inpatient hospital facility services	$250/admission + 20%
• Outpatient chemical dependency services	$20/visit[1]
HOME HEALTH SERVICES[4]	
• Home health care agency services (Maximum of 100 prior authorized visits per calendar year)	20%
• Home infusion/Home injectable therapy provided by a home infusion agency	20%
OTHER	
Hospice program benefits[4]	
• Routine home care	No charge
• Inpatient respite care	No charge
• 24-hour continuous home care	20%
• General inpatient care	20%
Chiropractic benefits[8]	
• Chiropractic services – provided by a chiropractor (Up to 26 visits per calendar year combined with rehabilitation services)	$20/visit[1]
Acupuncture benefits[8]	
• Acupuncture services (12 visits per calendar year; up to $50/visit)	$20/visit
Rehabilitation services (physical, occupational and respiratory therapy)	
• In an office location (Up to 26 visits per calendar year combined with chiropractic services)	$20/visit[1]
Speech therapy benefits	
• In an office location (Speech therapy services by a licensed speech pathologist or certified speech therapist)	$20/visit[1]
Pregnancy and maternity care	
• Prenatal and postnatal physician office visits (For inpatient hospital services, see "Hospitalization Services.")	No charge
Family planning benefits	
• Counseling and consulting	$20/visit[1]
• Infertility services (Diagnosis and treatment of causes of infertility. Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT)	50% of allowed charges
• Elective abortion[9]	$100
• Tubal ligation[9]	$100
• Vasectomy[9]	$75
Diabetes care benefits	
• Devices, equipment, and non-testing supplies	No charge
• Diabetes self-management training (If billed by your provider, you will also be responsible for the office visit copayment)	$20/visit[1]

Care Outside of Plan Service Area Benefits provided through BlueCard® Program, for out-of-state emergency and non-emergency care, are provided at the preferred level of the local Blue Plan allowable amount when you use a Blue Cross/Blue Shield provider.	
• Within US: BlueCard Program	See Applicable Benefit
• Outside of US: BlueCard Worldwide	See Applicable Benefit

1 Deductible and copayments marked with a (1) do not accrue to calendar-year copayment maximum. Copayments and charges for services not accruing to the member's calendar-year copayment maximum continue to be the member's responsibility after the calendar-year copayment maximum is reached. Deductible does not apply toward the calendar-year maximum. Please refer to the Plan Contract for exact terms and conditions of coverage.
2 Member is responsible for copayment in addition to any charges above allowable amounts. The copayment percentage indicated is a percentage of allowable amounts. Preferred providers accept Blue Shield's allowable amount as full payment for covered services. Non-preferred providers can charge more than these amounts. When members use non-preferred providers, they must pay the applicable copayment plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the calendar-year deductible or copayment maximum.
3 Participating ambulatory surgery centers may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital or an ambulatory surgery center affiliated with a hospital, with payment according to your health plan's hospital services benefits.
4 Out of network home health care, home infusion and hospice services are not covered unless pre-authorized. When these services are pre-authorized, the member pays the Preferred Provider copayment
5 Bariatric surgery is covered when pre-authorized by Blue Shield. However, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara and Ventura Counties ("Designated Counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons; coverage is not available for bariatric services from any other preferred provider and there is no coverage for bariatric services from non-preferred Providers. In addition, if prior authorized by Blue Shield of California, a member in a Designated County who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the Plan Contract for further benefit details.
6 Services may require prior authorization by Blue Shield. When these services are prior authorized, members pay the preferred or participating provider amount.
7 Mental health services are accessed through Blue Shield using Blue Shield's participating and non-participating providers. For a listing of severe mental illnesses, including serious emotional disturbances of a child, and other benefit details, please refer to the Plan Contract.
8 All outpatient acupuncture and chiropractic visits accrue to the calendar-year visit maximum regardless of whether the plan deductible has been met.
9 Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply.
10 Inpatient services for acute detoxification are covered under the medical benefit; see hospitalization services for benefit details. Services for medical acute detoxification are accessed through Blue Shield using Blue Shield's preferred providers or non-preferred providers.

Plan designs may be modified to ensure compliance with state and federal requirements

(11/09) ASO_ME 092109 RDB 102609

ATTACHMENT A-7

County of Santa Barbara
Custom Shield Spectrum PPO℠ 500-80/60
Benefit Summary (For groups of 300 and above)
(Uniform Health Plan Benefits and Coverage Matrix)

Blue Shield of California

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Effective January 1, 2010

DEDUCTIBLES[1] (All providers combined)	**Preferred Providers**[2]	**Non-Preferred Providers**[2]
Calendar year medical deductible	$500 per individual $1,500 per family	
Calendar year Copayment Maximum[1] (Copayments for Preferred Providers accrue to both Preferred and Non-Preferred Provider Calendar-year Copayment Maximum amounts.)	$4,000 per individual $8,000 per family	$6,000 per individual $12,000 per family
LIFETIME MAXIMUM	$6,000,000	

Covered Services	Member Copayment	
PROFESSIONAL SERVICES	**Preferred Providers**[2]	**Non-Preferred Providers**[2]
Professional (physician) benefits		
• Physician and specialist office visits	$30/visit[1] (Not subject to the Calendar-Year Deductible)	40%
• Diagnostic testing	20%	40%
• Outpatient X-ray, pathology and laboratory	20%	40%
Allergy testing and treatment benefits		
• Office visits (includes visits for allergy serum injections)	20%	40%
Preventive care benefits		
• Annual routine physical examination, vision and hearing screening and immunizations	$30/visit[1] (Not subject to the Calendar-Year Deductible)	40%
• Routine laboratory services, including annual mammography, Papanicolaou test, or cervical cancer and human papillomavirus (HPV) screening (One per calendar year)	$30/visit[1] (Not subject to the Calendar-Year Deductible)	40%
• Well baby care (Includes: eye/ear screenings, immunizations, vaccinations)	$30/visit[1] (Not subject to the Calendar-Year Deductible)	40%
• Well baby laboratory	$35/visit[1] (Not subject to the Calendar-Year Deductible)	40%
OUTPATIENT SERVICES		
Hospital benefits (facility services) The maximum allowed charges for non-emergency surgery and services performed in a non-participating Ambulatory Surgery Center or outpatient unit of a non-preferred hospital is $350 per day. Members are responsible for 40% of this $350 per day, plus all charges in excess of $350.		
• Outpatient surgery performed in a Participating Ambulatory Surgery Center (ASC)[3]	20%	40%
• Outpatient surgery in a hospital	20%	40%
• Outpatient services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation services")	20%	40%
• Bariatric surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity)[5]	20%	40%
HOSPITALIZATION SERVICES		
Hospital benefits (facility services)		
• Inpatient physician benefits	20%	40%
• Semi-private room and board, medically necessary services and supplies	$250/admission + 20%	40%[4]
• Bariatric surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity)[5]	$250/admission + 20%	40%[4]
Skilled nursing facility benefits[6] (Combined maximum of up to 100 preauthorized days per calendar year; semi-private accommodations)		
• Skilled nursing free standing facility	20%	20% with prior authorization[6]
• Skilled nursing facility unit of a hospital	20%	40%[4]

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ATTACHMENT A-7

Service		
EMERGENCY HEALTH COVERAGE		
• Emergency room services not resulting in admission (If ER services do not result in a direct admission the Calendar-Year Deductible does not apply)	$75[1] + 20%	$75[1] + 20%
• Emergency room services resulting in admission (when the member is admitted directly from the ER)	$250/admission + 20%	$250/admission + 20%
• Emergency room physician services	20%	20%
AMBULANCE SERVICES		
• Emergency or authorized transport	20%	20%
PROSTHETICS/ORTHOTICS		
• Prosthetic equipment and devices (Separate office visit copay may apply)	20%	40%
• Orthotic equipment and devices (Separate office visit copay may apply)	20%	40%
DURABLE MEDICAL EQUIPMENT		
• Durable medical equipment services	20%	40%
Hearing Aid		
• Hearing Aid Instrument and ancillary equipment (Up to a maximum of $700 per member every 24 months for the hearing aid and ancillary equipment)	20%	20%
MENTAL HEALTH SERVICES (PSYCHIATRIC)[7]		
• Inpatient hospital facility services	$250/admission + 20%	40%[4]
• Outpatient mental health services	$30/visit[1] (Not subject to the Calendar-Year Deductible)	40%
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)[9]		
• Inpatient hospital facility services	$250/admission + 20%	40%[4]
• Outpatient chemical dependency services	$30/visit[1] (Not subject to the Calendar-Year Deductible)	40%
HOME HEALTH SERVICES[10]		
• Home health care agency services (Maximum of 100 prior authorized visits per calendar year)	20%	Not covered[10]
• Home infusion/Home injectable therapy provided by a home infusion agency	20%	Not covered[10]
OTHER		
Hospice program benefits[10]		
• Routine home care	No charge	Not covered[10]
• Inpatient respite care	No charge	Not covered[10]
• 24-hour continuous home care	20%	Not covered[10]
• General inpatient care	20%	Not covered[10]
Chiropractic benefits[8]		
• Chiropractic services – provided by a chiropractor (Up to 26 visits per calendar year combined with rehabilitation services)	20%	Not covered
Acupuncture benefits[8]		
• Acupuncture services (12 visits per calendar year; up to $50/visit)	20%	20%
Rehabilitation services[8] (physical, occupational and respiratory therapy)		
• In an office location (Up to 26 visits per calendar year combined with chiropractic services)	20%	40%
Speech therapy benefits		
• In an office location (Speech therapy services by a licensed speech pathologist or certified speech therapist)	20%	40%
Pregnancy and maternity care		
• Prenatal and postnatal physician office visits (For inpatient hospital services, see "Hospitalization Services.")	20%	40%
Family planning benefits		
• Counseling and consulting	$30/visit[1] (Not subject to the Calendar-Year Deductible)	Not covered
• Elective abortion[11]	20%	Not covered
• Tubal ligation[11]	20%	Not covered
• Vasectomy[11]	20%	Not covered
Diabetes care benefits		
• Devices, equipment, and non-testing supplies	20%	40%
• Diabetes self-management training (If billed by your provider, you will also be responsible for the office visit copayment)	$30/visit[1] (Not subject to the Calendar-Year Deductible)	40%

Care Outside of Plan Service Area Benefits provided through BlueCard® Program, for out-of-state emergency and non-emergency care, are provided at the preferred level of the local Blue Plan allowable amount when you use a Blue Cross/Blue Shield provider.		
• Within US: BlueCard Program	See Applicable Benefit	See Applicable Benefit
• Outside of US: BlueCard Worldwide	See Applicable Benefit	See Applicable Benefit

1 Deductible and copayments marked with a (1) do not accrue to calendar-year copayment maximum. Copayments and charges for services not accruing to the member's calendar-year copayment maximum continue to be the member's responsibility after the calendar-year copayment maximum is reached. Deductible does not apply toward the calendar-year maximum. Please refer to the Plan Contract for exact terms and conditions of coverage.
2 Member is responsible for copayment in addition to any charges above allowable amounts. The copayment percentage indicated is a percentage of allowable amounts. Preferred providers accept Blue Shield's allowable amount as full payment for covered services. Non-preferred providers can charge more than these amounts. When members use non-preferred providers, they must pay the applicable copayment plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the calendar-year deductible or copayment maximum.
3 Participating ambulatory surgery centers may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital or an ambulatory surgery center affiliated with a hospital, with payment according to your health plan's hospital services benefits.
4 The maximum allowed charges for non-emergency hospital services received from a non-preferred hospital is $600 per day. Members are responsible for 40 percent of this $600 per day, plus all charges in excess of $600.
5 Bariatric surgery is covered when pre-authorized by Blue Shield.
6 Services may require prior authorization by Blue Shield. When these services are prior authorized, members pay the preferred or participating provider amount.
7 Mental health services are accessed through Blue Shield - using Blue Shield participating and non-participating providers. For a listing of severe mental illnesses, including serious emotional disturbances of a child, and other benefit details, please refer to the Plan Contract.
8 All outpatient chiropractic, rehabilitation and acupuncture visits accrue to the calendar-year visit maximum regardless of whether the plan deductible has been met.
9 Inpatient services for acute detoxification are covered under the medical benefit; see hospitalization services for benefit details. Services for medical acute detoxification are accessed through Blue Shield using Blue Shield's preferred providers or non-preferred providers.
10 Out of network home health care, home infusion and hospice services are not covered unless pre-authorized. When these services are pre-authorized, the member pays the Preferred Provider copayment.
11 Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply.

Plan designs may be modified to ensure compliance with state and federal requirements

ATTACHMENT A-8

County of Santa Barbara
Custom PPO℠ Savings Plus 1500
Benefit Summary (For groups of 300 and above)

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE *PLAN CONTRACT* SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

(Uniform Health Plan Benefits and Coverage Matrix)

Highlights: $1,500 individual coverage deductible or $3,000 family coverage deductible

Effective January 1, 2010

DEDUCTIBLES	**Preferred Providers[1]**	**Non-Preferred Providers[1]**
Calendar year medical deductible (All providers combined) (Note: For family coverage, the full family deductible must be met before the enrollee or covered dependents can receive benefits for covered services.)	$1,500 per individual $3,000 per family	
Calendar year out-of-pocket maximum[1] (Includes the plan deductible) (Note: For family coverage, the full family out-of-pocket maximum must be met before the enrollee or covered dependents can receive 100% benefits for covered services.)	$4,500 per individual $9,000 per family	
LIFETIME MAXIMUM	$6,000,000	

Covered Services	Member Copayment	
PROFESSIONAL SERVICES	**Preferred Providers[1]**	**Non-Preferred Providers[1]**
Professional (physician) benefits		
• Physician and specialist office visits	20%	40%
• Outpatient X-ray, pathology and laboratory	No charge	40%
Allergy testing and treatment benefits		
• Office visits (includes visits for allergy serum injections)	20%	40%
Preventive care benefits		
• Annual routine physical examination, vision and hearing screening and immunizations	No charge[2]	40%
• Routine laboratory services, including annual mammography, Papanicolaou test, or cervical cancer and human papillomavirus (HPV) screening	No charge[2]	40%
• Well baby care (Includes: eye/ear screenings, immunizations, vaccinations)	20%[2]	40%
• Well baby laboratory	20%[2]	40%
OUTPATIENT SERVICES		
Hospital benefits (facility services) The maximum allowed charges for non-emergency surgery and services performed in a non-participating Ambulatory Surgery Center or outpatient unit of a non-preferred hospital is $350 per day. Members are responsible for 40% of this $350 per day, plus all charges in excess of $350.		
• Outpatient surgery performed in a Participating Ambulatory Surgery Center (ASC)[3]	20%	40%
• Outpatient surgery in a hospital	20%	40%
• Outpatient services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation services")	20%	40%
• Bariatric surgery[5] (pre-authorization required; medically necessary surgery for weight loss, for morbid obesity only)	20%	40%
HOSPITALIZATION SERVICES		
Hospital benefits (facility services)		
• Inpatient physician benefits	20%	40%
• Semi-private room and board, medically necessary services and supplies	20%	40%[4]
• Bariatric surgery[5] (pre-authorization required; medically necessary surgery for weight loss, for morbid obesity only)	20%	40%[4]
Skilled nursing facility benefits[6] (Combined maximum of up to 100 preauthorized days per calendar year; semi-private accommodations)		
• Skilled nursing free standing facility	20%	20% with prior authorization[6]
• Skilled nursing facility unit of a hospital	20%	40%[4]
EMERGENCY HEALTH COVERAGE		
• Emergency room services not resulting in admission (ER Facility copay does not apply if the member is admitted directly from the ER for inpatient services.)	20%	20%
• Emergency room services resulting in admission (when the member is admitted directly from the ER)	20%	20%
• Emergency room physician services	20%	20%

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AMBULANCE SERVICES		
• Emergency or authorized transport	20%	20%
PRESCRIPTION DRUG COVERAGE[7, 8, 9, 10, 11, 12]		
(Subject to deductible; includes oral contraceptives, diaphragms, and covered diabetic drugs and testing supplies)		
Outpatient Prescription Drug Benefits	**Participating Pharmacy**	**Non-Participating Pharmacy**
Retail prescriptions (For up to a 30-day supply)		
• Generic drugs	20%	20%
• Formulary brand name drugs	20%	20%
• Non-formulary brand name drugs	20%	20%
• Home self-administered injectable medications (Available at specialty pharmacy network only)	20% up to $100 per prescription	Not covered
Mail service prescriptions (For up to a 90-day supply)		
• Generic drugs	20%	Not covered
• Formulary brand name drugs	20%	Not covered
• Non-formulary brand name drugs	20%	Not covered
• Home self-administered injectable medications	Not covered	Not covered
PROSTHETICS/ORTHOTICS		
• Prosthetic equipment and devices (Separate office visit copay may apply)	20%	40%
• Orthotic equipment and devices (Separate office visit copay may apply)	20%	40%
DURABLE MEDICAL EQUIPMENT		
• Durable medical equipment services	20%	40%
Hearing Aid		
• Hearing Aid Instrument and ancillary equipment (Up to a maximum of $700 per member every 24 months for the hearing aid and ancillary equipment)	20%	20%
MENTAL HEALTH SERVICES (PSYCHIATRIC)[13]		
• Inpatient hospital facility services	20%	40%[4]
• Outpatient mental health services	20%	40%
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)[15]		
• Inpatient hospital facility services	20%	40%[4]
• Outpatient chemical dependency services	20%	40%
HOME HEALTH SERVICES[16]		
• Home health care agency services (Up to 100 prior authorized visit maximum per calendar year)	20%	Not covered[16]
• Home infusion/home injectable therapy provided by a home infusion agency	20%	Not covered[16]
OTHER		
Hospice program benefits[16]		
• Routine home care	No charge	Not covered[16]
• Inpatient respite care	No charge	Not covered[16]
• 24 hour continuous home care	20%	Not covered[16]
• General inpatient care	20%	Not covered[16]
Chiropractic benefits[14]		
• Chiropractic services – provided by a chiropractor (Up to 26 visits per calendar year combined with rehabilitation services)	20%	Not covered
Acupuncture benefits[14]		
• Acupuncture services (Up to 12 visits per calendar year; $50/visit)	20%	20%
Rehabilitation services (physical, occupational and respiratory therapy)[14]		
• In an office location (Up to 26 visits per calendar year combined with chiropractic services)	20%	Not covered
Speech therapy benefits		
• In an office location (Speech therapy services by a licensed speech pathologist or certified speech therapist)	20%	40%
Pregnancy and maternity care benefits		
• Prenatal and postnatal physician office visits (For inpatient hospital services, see "Hospitalization Services.")	20%	40%
Family planning benefits		
• Counseling and consulting	20%	Not covered
• Tubal ligation[17]	20%	Not covered
• Elective abortion[17]	20%	Not covered
• Vasectomy[17]	20%	Not covered

Diabetes care benefits		
• Devices, equipment and non-testing supplies (For testing supplies, see "Outpatient Prescription Drug Coverage.")	20%	40%
• Diabetes self-management training (If billed by your provider, you will also be responsible for the office visit copayment)	20%	40%
Care outside of plan service area (Benefits provided through the BlueCard® Program) Benefits provided through BlueCard Program, for out-of-state emergency and non-emergency care, are provided at the preferred level of the local Blue Plan allowable amount when you use a Blue Cross/Blue Shield provider.		
• Within US: BlueCard Program	See Applicable Benefit	See Applicable Benefit
• Outside of US: BlueCard Worldwide	See Applicable Benefit	See Applicable Benefit

1 Member is responsible for copayment in addition to any charges above allowable amounts. The coinsurance indicated is a percentage of allowed amounts. Preferred providers accept Blue Shield of California allowable amount as full payment for covered services. Non-preferred providers can charge more than these amounts. When members use non-preferred providers, they must pay the applicable copayment plus any amount that exceeds Blue Shield Life's allowable amount. Charges in excess of the allowable amount do not count toward the calendar-year deductible or out-of-pocket maximum. Payments applied to your Calendar Year Deductible accrue towards the Maximum Calendar Year Out-of-Pocket Responsibility.

2 The preventive care and well-baby care office visit are not subject to the plan deductible. Other covered non-preventive services received during or in connection with the office visit are subject to the plan deductible and the applicable copayment percentage.

3 Participating ambulatory surgery centers may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital or an ambulatory surgery center affiliated with a hospital, with payment according to your health plan's hospital services benefits.

4 The maximum allowed charge for non-emergency hospital services received from a non-preferred hospital is $600 per day. Members are responsible for 40 percent of this $600 per day, plus all charges in excess of $600. Payments that exceed the allowed charge do not count toward the calendar-year out-of-pocket maximum, and continue to be charged after it is reached.

5 Bariatric surgery is covered when pre-authorized by Blue Shield.

6 Services may require prior authorization by Blue Shield. When services are prior authorized, members pay the preferred or participating provider amount.

7 This plan's prescription drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called "creditable" coverage). Since this plan's prescription drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you have a subsequent break in this coverage of 63 days or more before enrolling in Medicare Part D you could be subject to payment of higher Medicare Part D premiums.

8 If the member requests a Brand Name Drug when a Generic Drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield of the Brand Name Drug and its Generic Drug equivalent, as well as the applicable Generic Drug Copayment. This difference in cost that the member must pay is not applied to the Calendar Year Deductible and is not included in the Calendar Year maximum out-of-pocket responsibility calculations.

9 Please note that if you switch from another plan, your prescription drug deductible credit from the previous plan during the calendar year, if applicable, will not carry forward to your new plan.

10 For the Outpatient Drugs benefit, covered drugs obtained from Non-Participating Pharmacies will be subject to and accrue to the deductible and the copay maximum for Preferred Providers.

11 Home self-administered injectable drugs are covered only when dispensed by select pharmacies in the Specialty Pharmacy Network unless Medically Necessary for a covered emergency.

12 Selected formulary and non-formulary drugs and most home self-administered injectables require prior authorization by Blue Shield for Medical Necessity, and when effective, lower cost alternatives are available.

13 Mental health services are accessed through Blue Shield of California - using Blue Shield's participating and non-participating providers. For a listing of severe mental illnesses, including serious emotional disturbances of a child, and other benefit details, please refer to the Plan Contract or Group Policy.

14 Chiropractic, acupuncture and rehabilitative visits accrue to the calendar-year visit maximum regardless of whether the plan deductible has been met.

15 Inpatient services for acute detoxification are covered under the medical benefit; see hospitalization services for benefit details. Services for medical acute detoxification are accessed through Blue Shield using Blue Shield's preferred providers or non-preferred providers.

16 Out of network home health care, home infusion and hospice services are not covered unless pre-authorized. When these services are pre-authorized, the member pays the Preferred Provider copayment.

17 Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply.

Plan designs may be modified to ensure compliance with state and federal requirements

Rate Summary – Early Retirees

ATTACHMENT A-9

Medical Coverages	EE's	Aetna Current	Aetna Renewal		Blue Shield / CSAC-EIA
Low HMO					EPO
Early Retirees					
Employee Only	230	$619.10	$821.85		$787.09
Employee + 1	72	$1,151.99	$1,529.26		$1,456.12
Family	5	$1,795.47	$2,383.48		$2,286.42
	307		32.7%		26.9%
High HMO					EPO
Early Retirees					
Employee Only	26	$917.82	$1,318.93		$906.36
Employee + 1	8	$1,704.37	$2,449.23		$1,676.78
Family	0	$2,665.79	$3,830.82		$2,632.88
	34		43.7%		-1.4%
POS					PPO
Early Retirees					
Employee Only	16	$1,063.33	$1,029.38		N/A
Employee + 1	1	$1,967.14	$1,904.33		
Family	0	$3,083.64	$2,985.17		
	17		-3.2%		
PPO					
Early Retirees					
Employee Only	76	$567.19	$832.63	92	$806.88
Employee + 1	67	$1,049.30	$1,540.35	68	$1,492.73
Family	3	$1,644.85	$2,414.61	3	$2,346.68
	146		46.8%	163	54.4%
HDHP					
Early Retirees					
Employee Only	42	$454.42	$434.79		$595.42
Employee + 1	23	$845.01	$808.50		$1,101.53
Family	3	$1,316.86	$1,259.96		$1,731.69
	68		-4.3%		30.8%
Passive PPO					
Early Retirees					
Employee Only	11	$567.19	$794.75		$806.88
Employee + 1	7	$1,049.30	$1,470.29		$1,492.73
Family	0	$1,644.85	$2,304.78		$2,346.68
	18		40.1%		42.3%

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Rate Summary – Post-65 Retirees

ATTACHMENT A-10

Medical Coverages	EE's	Aetna Current	Aetna Renewal		Blue Shield / CSAC-EIA
Low HMO					*EPO*
Post-65 Retirees					
Employee Only	394	$256.20	$446.96		$421.00
Employee + 1	99	$512.40	$893.91		$842.00
	493		74.5%		64.3%
High HMO					*EPO*
Post-65 Retirees					
Employee Only	213	$403.30	$476.33		$431.57
Employee + 1	37	$806.60	$952.65		$863.15
	250		18.1%		7.0%
POS					*PPO*
Post-65 Retirees					
Employee Only	61	$524.35	$468.21		N/A
Employee + 1	9	$1,048.70	$936.42		
	70		-10.7%		
PPO					
Post-65 Retirees					
Employee Only	196	$422.98	$394.25	257	$481.00
Employee + 1	56	$845.95	$788.49	65	$962.00
	252		-6.8%	322	42.9%
HDHP					*PPO*
Post-65 Retirees					
Employee Only	4	$338.38	$434.13		$481.00
Employee + 1	4	$676.76	$868.27		$962.00
	8		28.3%		42.1%
Passive PPO					
Post-65 Retirees					
Employee Only	13	$441.61	$314.14		$481.00
Employee + 1	3	$883.22	$628.28		$962.00
	16		-28.9%		8.9%

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