

KENT COUNTY LEVY COURT

REQUEST FOR PROPOSALS:

EMPLOYEE HEALTH/MEDICAL INSURANCE

JANUARY 29, 2010

Prepared By:

KENT COUNTY LEVY COURT

*Personnel Office*

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**SECTION I: INTRODUCTION**

**A. Purpose**

The purpose of this Request for Proposals (the "RFP") is to procure high quality health/medical insurance benefits for the employees of Kent County Levy Court (KCLC) through a fully insured or self insured format.

**B. Background**

Kent County Levy Court (KCLC) is the governing body for one of the three counties comprising the State of Delaware. Kent County is centrally located and is home to the State capital - Dover, which is also the county seat. The current population is estimated to be 158,000.

The County currently has 292 full time employee positions authorized to work at the Kent County Administrative Complex located at 555 Bay Road, Dover, Delaware; the Kent County Courthouse at 38 The Green, Dover, Delaware; the Kent County Wastewater Treatment Facility near Frederica, Delaware; the Emergency Services Building at 911 Public Safety Blvd., Dover, Delaware; Emergency Medical Services Station #66 located at 5100 Wheatley's Pond Road, Smyrna, Delaware; Emergency Medical Services Station #68 located at the Harrington Fire hall at 20 Clark Street, Harrington, Delaware, and a leased office building for the Kent County Library located at 2319 S. Dupont Hwy. in Dover, Delaware. The seven (7) elected Levy Court Commissioners, the current five (5) elected row office officials and their nine (9) appointed deputies, and the three (3) appointed members of the Board of Assessment are considered full-time employees for insurance purposes. The County also provides health/medical insurance including prescription coverage to 89 retirees participating in the GASB 45 compliant Retiree Benefits Program.

KCLC has offered a premium based health/medical insurance program since June 1, 1998 and previously operated a self insured employee health/medical insurance program, including prescriptions, using a third party administrator. The current plan year will expire on June 30, 2010. The current plan consists of 353 units as of January 1, 2010.

The current distribution breakdown includes 248 full-time employee participants (which include elected officials), 37 retired participants, one (1) COBRA eligible participant, and 67 retired Medicare-eligible participants. Part-time employees are not eligible for any KCLC employee insurance. Of the current 286 employee/non-Medicare eligible retiree units, 157 have employee only coverage, 35 have retiree only coverage, 23 have employee and spouse coverage, 3 have retiree and spouse coverage; 37 have employee and child(ren) coverage, and 31 have family coverage. Of the 67 Medicare eligible retirees, 56 have single coverage, and 11 have retiree and spouse coverage. A choice between PPO-100%/75%, PPO-90%/70%, HMO-100%, and HMO-80% plans are presently offered to employees.

KCLC currently pays 100% of the employee portion, and the employee pays the difference for dependent coverages less a 60% contribution by KCLC. There are currently 14 vacant positions and 38 (27/11) employees/retirees have waived coverage. See exhibits for plan details and prescription coverages.

TYPE – 01/01/10	HMO-HIGH	COBRA	HMO-LOW	PPO - HIGH	PPO - LOW	MEDIGAP	COBRA
Employee	54	0	2	101	0	0	
Retiree	13	1	1	20	0	56	0
Emp & Spouse	10	0	0	13	0	0	
Retiree & Spouse	1	0	0	2	0	11	0
Emp & child	14	0	0	23	0		
Emp & Family	20	0	1	10	0		
TOTAL	112	1	4	169	0	67	0

The current insurer’s 2009-2010 monthly premiums rates are as follows:

<i>Blue Cross Blue Shield of Delaware, Inc.</i>	<i>Employee</i>	<i>w/Spouse</i>	<i>w/Child(ren)</i>	<i>w/Family</i>
Preferred Provider (PPO-Hi Option)	\$669.32	\$1,539.43	\$1,070.91	\$1,874.10
Preferred Provider (PPO-Low Option)	\$627.76	\$1,443.84	\$1,004.41	\$1,757.72
HMO High (IPA 100%)	\$614.31	\$1,412.91	\$982.90	\$1,720.07
HMO Low (IPA 80%)	\$568.13	\$1,306.70	\$909.01	\$1,590.76
Special Medicfill (Medicare supplement)	\$337.34	\$674.68		

In 2006, KCLC engaged an employee benefits consulting firm, Bolton Partners, Inc. of Baltimore, MD, to review the County’s medical claims history and recommend whether or not to consider self insurance again. The report recommends that the County carefully review fully and self insured programs following a competitive bid process. The consultant also assisted the County in qualifying for the Retiree Drug Subsidy program offered through the Centers for Medicare & Medicaid Services under the Part “D” Medicare benefit. The County currently uses Boomershine Consulting Group, LLC in Ellicott City, MD as its Retiree Drug Subsidy program consultant.

**Section II. SCOPE OF SERVICES**

**The health/medical insurance provider/bidder will be expected at a minimum to provide the following:**

1. A Base Proposal providing coverage (within the parameters given) which at a minimum is equal to or more comprehensive than the current coverages offered to employees and retirees (and their eligible dependents), including a Medicare supplement(s), by KCLC summarized in Exhibit B(1), B(2), B(3), & B(4);
2. Provider networks must include a minimum of 25 licensed physicians with offices offering full time regular office hours in Kent County with at least five (5) primary or general practice medical doctors accepting new patients over 17 and at least two (2) pediatricians accepting new patients under 18 at all times during the term of the contract;
3. Bayhealth Medical Services/Kent General Hospital & Milford Memorial Hospital and all related hospital services (emergency room, anesthesiology, radiology, etc.) must be

included and available at all times as an approved provider under all health/medical plans offered;

4. Prescription drug program must be included as part of health/medical plan and accepted at a minimum of 75% of the pharmacies dispensing drugs within Kent County with availability in each metropolitan area (Dover, Smyrna, Harrington, and Milford);

5. With input and final approval of form by KCLC staff, develop, prepare and present in an understandable manner such reports desired by KCLC to assist in cost management;

6. Develop, prepare and present phantom or other rates using standard actuarial practices to assist KCLC in appropriately budgeting the plan;

7. Insure that physician/service provider charges are reasonable and customary and equal to those rates negotiated by the bidder;

8. Respond to inquiries as directed by the KCLC or KCLC staff;

9. Advise KCLC concerning Federal, State or other regulatory issues;

10. Keep KCLC abreast of Plan Benefit design trends and options;

11. Maintain an active role in assuring the KCLC's Plan (s) is running efficiently;

12. Participate, as requested, in informational meetings with KCLC employees to answer questions, discuss or promote the plan(s) and meet regularly with KCLC staff;

13. With input and final approval by KCLC staff, develop, print and distribute adequate number of copies of informational booklets for current and new employees outlining specific benefit plans, benefits explanation, typical questions, etc. (Initial informational books must be published within 90 days of award);

14. Provide at no additional cost identification cards required to access services, plan booklet changes, customer service, utilization review and other reports, commissions, etc. Such cards to be provided to existing employees on or before the plan effective date and within 30 days for new enrollees;

15. Provide a toll free customer service telephone number with adequate staffing to answer benefit and claims related questions;

16. Process and pay health care providers within thirty (30) days of correct invoice submission for at least ninety (90) percent of total claims submitted per month;

17. Provide at no additional cost complete electronic copies in an approved electronic format of the Summary Plan Document, approved contract for services, and other related documents; and

18. Coordinate with our Benefits Consultant and provide at a reasonable cost or at

no cost necessary data formatted as required by the Centers for Medicare & Medicaid Services to facilitate eligibility and application for and receipt of a Retiree Drug Subsidy.

### **SECTION III. TECHNICAL PROPOSAL AND FORMAT**

**All proposals shall respond to all questions and requirements listed in this RFP, except that Section III may be waived for the existing broker and insurer if no changes have occurred since the previous submission and award.**

#### **A. Basic Information**

1. State the name of your firm, address, telephone and telefax numbers and the name and title of the person who will serve as the KCLC's key contact with your firm.
2. Provide a general description of the firm, including size, number of employees, primary business (consulting, pension planning, insurance, etc.), other business or services, type of organization (franchise, corporation, partnership, etc.), and other descriptive material.
3. Provide an explanation of your claims processing and the claims appeals processes and normal time required to process payments. Indicate type and number of forms expected to be regularly completed by plan participants.
4. Describe processes used to insure timely responses to inquiries and processing of claims.

#### **B. Financial Condition**

1. Has your firm experienced any significant financial difficulties or other problems which could negatively affect its ability to carry out its duties and responsibilities to KCLC? If yes, please specifically identify the problem(s) and discuss why such problems should be disregarded.
2. Provide a specific authorization in a form acceptable to the Delaware Insurance Department to authorize disclosure of information relating to your firm's financial status and market conduct practices.
3. Does your firm possess a certificate of authority issued by the Delaware Insurance Department to conduct, transact insurance business in this jurisdiction?

#### **C. Personnel Assigned**

1. Identify the account manager(s) of your firm who will be involved with this engagement, i.e.- the person who will have the direct reporting and administrative responsibility to the KCLC. Please indicate the status of this individual within your organization and his/her professional background and experience. Provide other relevant information regarding this individual (s). Furnish current references including names, titles, affiliations and telephone numbers

of clients with whom this individual has had responsibility.

2. Provide professional backgrounds for all associates and other personnel who will be involved with the engagement.

3. Describe your organizational approach to this engagement; utilize, if appropriate, an organizational table. Explain how the various professionals and staff will be organized and managed.

**D. Experience**

1. Describe your firm's experience in providing the requested services. Highlight those engagements which involved Delaware and nearby entities. If representing an insurer, please provide that firm's experience and engagements.

2. Attach samples of informational or similar publications, if any, provided to clients and interested parties on a routine basis.

3. Attach samples of billing statement and similar type reports.

4. Provide information about any national accreditations received for operations, programs, plans, etc., (i.e., NCQA).

**SECTION IV: COST PROPOSAL AND FORMAT**

The Base Proposal plan design(s) proposed must at a minimum be equal to or better than the current coverage offered to employees by KCLC summarized in Exhibit B with full details included as an attachment in Exhibit C.

Any Health/Medical Insurance Base Proposal offering PPO 100/75%, PPO 90/70%, HMO 100%, HMO 80%, and/or Medicare supplement plans must at a minimum provide equal or better than current coverage (benefits) offered to employees/retirees through the existing KCLC health/medical plan with the same deductible, coinsurance, copayment, etc. or referral requirements. If vision benefits are not offered as part of the basic plan, please list and price as an optional benefit.

Alternative proposals with differing plan designs and coverages are welcome, but must be accompanied with details sufficient to ascertain the differences between current coverage and proposed coverage and related costs. Any alternatives proposed must specifically identify those requirements listed in the Scope of Services (Section II) not provided.

The Base Proposal cost information should be provided in the tabular format as provided in Exhibit A, if feasible. Failure to provide all cost information and in the order specified may result in the rejection of the Base Proposal.

Bidders may not make major changes to Base Proposal forms or Base Proposal Plans, if such changes cannot be easily understood or appear incomplete it may result in the rejection of the Base proposal.

**SECTION V: GENERAL INFORMATION AND INSTRUCTIONS FOR BIDDING**

**A. Issuing Office**

This request for proposals is being issued by the Personnel Office in conjunction with the Finance Department of Kent County Levy Court. Unless otherwise specified, Personnel Director Allan Kujala of the KCLC Personnel Office is the sole point of contact for the purposes of the RFP and subsequent responses of substance will be in writing.

**B. Scope of Engagement**

KCLC is requesting proposals to provide employee health/medical insurance and/or employee health/medical insurance related services for a one (1) year period with possible extension for an additional one (1), two (2), or three (3) years at the option of KCLC. It is the desire of KCLC to award a two (2) or three (3) year contract if cost effective and in the best interest of KCLC employees and the public. *If final award is for a one (1) year period, KCLC reserves the right to renew or extend the services agreement with the successful bidder for an additional one (1) or two (2) years if cost effective and in the best interest of KCLC employees and the public.*

**C. Addendum to RFP**

The KCLC reserves the right to amend the RFP prior to the due date of responses. If it becomes necessary to revise any part of the RFP, an addendum shall be provided to all bidders who have been sent a copy of this RFP. All bidders shall include acknowledgment of all addenda as part of this proposal. Failure to acknowledge addenda may be grounds for disqualification of the proposal. Any addendum will also be available on the County's web site www.co.kent.de.us

**D. Cost of Preparing Proposal**

The cost of developing and submitting the proposal is entirely the responsibility of the bidder. This includes costs to determine the nature of this engagement, preparation of proposal, submission of proposal, negotiation for the contract, and all other costs associated with this RFP and responses thereto. All responses and any future publications, if contract awarded, will become the property of the KCLC. The responses of successful bidder(s) may be a matter of public record subsequent to award of the contract.

**E. Submissions of proposals**

Five (5) copies of each vendor's proposal(s) shall be submitted in a sealed package marked "EMPLOYEE MEDICAL INSURANCE PROPOSAL" to **Allan Kujala, Personnel Director, Room 213, Kent County Administrative Complex, Kent County Levy Court, 555 Bay Road, Dover, DE 19901** no later than 4:00 p.m., E.S.T., on Wednesday, March 31, 2010.

**and**

One (1) electronic copy of each vendor's proposal(s) is requested to be submitted via e-mail and referenced as "EMPLOYEE MEDICAL INSURANCE PROPOSAL" to allan.kujala@co.kent.de.us no later than 4:00 p.m., E.S.T., on Wednesday, March 31, 2010.

All submitted proposals become the property of KCLC as public documents and are available for review by the public as provided by Law.

**F. Independent Price Determination**

A proposal will not be considered for award if the fees were not arrived at independently and without collusion, communication or agreement as to any matter related to such prices with any other vendor, competitor or public officer.

The vendor must include a signed statement in the proposal transmittal letter certifying that the price was arrived at without any conflict of interest.

**G. Preparation**

Responses should provide a straightforward, concise description of bidder's capabilities to satisfy the requirements of this RFP. Emphasis should be on completeness and clarity of content. Repetition of the terms and conditions of the RFP, without additional explanation, will not be considered sufficiently responsive.

**H. Errors in Proposal Preparation**

The KCLC has the right to rely on any price quotes provided by bidders. The bidders may be responsible for any mathematical error or incorrect extension of any calculations leading to the bidder's price quotes. The KCLC reserves the right to reject proposals which contain errors.

**I. Evaluation of Proposals**

All proposals submitted in response to the RFP will be evaluated by the KCLC, with consideration focused toward, but not limited to, the following:

1. Firm's qualifications and experience to provide the required service as defined in the RFP.
2. Adequate number of personnel with the qualifications required to provide the services as defined in the RFP.
3. Cost of services.
4. Value of any additional services to be provided, introduction/proposal of innovative concepts, and/or a demonstrated commitment to cost containment.
5. Firm's understanding of the KCLC's current and requested plan design(s).
6. Compliance with the terms, conditions and other provisions of the RFP.
7. Adequacy and completeness of the proposal with regard to the information specified in the RFP.

**J. Appearance Before KCLC Committee**

Any or all bidders may be required to appear before one or more KCLC Committee(s) to explain the bidder's understanding and approach to the insurances requested and/or respond to any questions in regard to the proposal submitted. The project manager shall, if possible, make any requested oral presentations before the KCLC Committee(s).

**K. Awards**

Awards will be made by the Kent County Levy Court consistent with 29 Del. C. §6924 and based upon the best potential interest of Kent County. The KCLC reserves the right to reject any or all responses to the RFP, for whatever reason deemed by it to be appropriate, and shall not be obligated to return any material in connection with this request. A satisfactory contract of agreement must be fully negotiated and executed by the insurer and presented for execution by KCLC within 60 days of award. If a satisfactory agreement cannot be reached in a timely manner, KCLC reserves the right to negotiate an agreement with another insurer. The KCLC reserves the right to place its employee health/medical insurance coverage(s) with the State of Delaware or the Delaware Founders Insurance Trust affiliated with the Delaware League of Local Governments or similar insurance pool without the requirement to submit a proposal or meet any of the conditions listed. The KCLC further reserves the right to seek "a best and final" offer from any or all of the bidders before making an award.

**L. Payments**

Payments to successful bidder(s) shall be on a monthly basis, unless otherwise agreed, and will be made in accordance with mutually agreeable terms by the KCLC.

**M. Political Involvement**

As this RFP has established specific criteria for evaluation of all proposals, bidders and their representatives may not contact elected officials directly or indirectly to lobby or otherwise secure undue support for a specific or general proposal(s) submitted. If such activity occurs, the proposal will be disqualified from further consideration.

**N. Availability for Questions**

Personnel Director Allan Kujala is generally available to answer relevant RFP related questions during normal business hours via telephone or electronic mail, but will be away from the office from February 1-15, 2010.

*NOTE: This RFP and some exhibits are available in electronic format upon request. Submit request by calling (302) 744-2310 during regular business hours or e-mail your request to personnel@co.kent.de.us. Please provide correct e-mail address to insure proper delivery.*

**EXHIBIT A  
FULLY INSURED HEALTH/MEDICAL INSURANCE PROGRAM  
BASE PROPOSAL QUOTE FORM 2010/2011**

**PLAN NAME** \_\_\_\_\_ **Broker** \_\_\_\_\_

Please provide a quote for fully insured health/medical insurance where the carrier/bidder assumes all risk for the plans outlined below. Fully insured plans proposed must at a minimum equal the current coverage provided and coverage parameters outlined in the document as well as specification listed in this document. All administrative, claims, commissions, etc. costs must be included on this quotation form.

Please provide a flat per month, per employee, employee & spouse, employee & child(ren) and employee & family monthly rate for PPO and HMO (high & standard/base type) and for Medicare Supplement coverage:

1) **Preferred Provider Organization**

*A. (100% in network, 75% out of network)      B. (90% in network, 70% out of network)*

Employee	\$ _____	Employee	\$ _____
Employee & spouse	\$ _____	Employee & spouse	\$ _____
Employee & child(ren)	\$ _____	Employee & child(ren)	\$ _____
Family (including employee)	\$ _____	Family (including employee)	\$ _____

2) **Health Maintenance Organization**

*A. (100% in network, 0% out of network)      B. (80% in network, 0% out of network)*

Employee	\$ _____	Employee	\$ _____
Employee & spouse	\$ _____	Employee & spouse	\$ _____
Employee & child(ren)	\$ _____	Employee & child(ren)	\$ _____
Family (including employee)	\$ _____	Family (including employee)	\$ _____

3) Medicare Supplement (including deductibles, and no prescription maximum)\*\*

	<i>SUPPLEMENT</i>
Retiree	\$ _____
Retiree & spouse	\$ _____

4) Retiree Drug Subsidy data (formatted to CMS standards for transfer to consultant)

Annual Data Transfer      \$ \_\_\_\_\_ (flat rate, if any cost)

EXHIBIT A (Continued)
FULLY INSURED HEALTH/MEDICAL INSURANCE PROGRAM
BASE PROPOSAL QUOTE FORM 2010/2011

PLAN NAME \_\_\_\_\_ Broker \_\_\_\_\_

ADDITIONAL QUOTE REQUESTED

Please provide a flat per month, per employee, employee & spouse, employee & child(ren) and employee & family monthly rate for the following additional coverages:

1) Vision Benefit (Equal or better than existing coverage)

Employee \$ \_\_\_\_\_
Employee & spouse \$ \_\_\_\_\_
Employee & child(ren) \$ \_\_\_\_\_
Family (including employee) \$ \_\_\_\_\_

Or check blank if

\_\_\_\_\_ Vision benefit included without additional cost

2) Hearing Benefit (To include testing and discount on hearing devices)
Fully explain coverage levels, limits and exclusions.

Employee \$ \_\_\_\_\_
Employee & spouse \$ \_\_\_\_\_
Employee & child(ren) \$ \_\_\_\_\_
Family (including employee) \$ \_\_\_\_\_

Or check blank if

\_\_\_\_\_ Hearing benefit included without additional cost

\*\*ALTERNATIVE QUOTE REQUESTED

Medicare Supplement (including deductibles, and prescriptions w/\$2,000 , or w/\$3,000)

Retiree w/\$2000 Rx Max. w/\$3,000 Rx Max.
Retiree & spouse

**EXHIBIT A1  
 SELF INSURED HEALTH/MEDICAL INSURANCE PROGRAM  
 REINSURANCE - BASE PROPOSAL QUOTE FORM 2010/2011  
 (Must also submit bid as third party administrator)**

**PLAN NAME** \_\_\_\_\_ **Broker** \_\_\_\_\_

Specific and aggregate stop loss insurance is on an incurred basis. Kent Count Levy Court shall select the final dollar limit for first year, subsequent years shall be based on 125% of actual claims for a minimum 9 month preceding period. Bidder may not substitute dollar limit figures or calculate a rate based on percentage of claims for first year.

Please provide a per month, per employee unit rate (inclusive of individual, family, spouse or child(ren) coverage) for each limit listed:

**SECTION I**

Specific Stop/Loss dollar limit	\$ <u>35,000</u>	\$ <u>45,000</u>	\$ <u>60,000</u>	\$ <u>75,000</u>
Proposed rate per employee unit	_____	_____	_____	_____
Proposed rate per emp/spouse unit	_____	_____	_____	_____
Proposed rate per emp/child unit	_____	_____	_____	_____
Proposed rate per emp/family unit	_____	_____	_____	_____

**SECTION II**

A) Aggregate Stop/Loss dollar limit of \$850,000:

Proposed rate per employee unit with Specific Stop/Loss dollar limit of:	_____	_____	_____	_____
	\$35,000	\$45,000	\$60,000	\$75,000

B) Aggregate Stop/Loss dollar limit of \$1,000,000:

Proposed rate per employee unit with Specific Stop/Loss dollar limit of:	_____	_____	_____	_____
	\$35,000	\$45,000	\$60,000	\$75,000

C) Aggregate Stop/Loss dollar limit of \$1,250,000:

Proposed rate per employee unit with Specific Stop/Loss dollar limit of:	_____	_____	_____	_____
	\$35,000	\$45,000	\$60,000	\$75,000

D) Aggregate Stop/Loss dollar limit of \$1,500,000:

Proposed rate per employee unit with Specific Stop/Loss dollar limit of:	_____	_____	_____	_____
	\$35,000	\$45,000	\$60,000	\$75,000

**EXHIBIT A1  
 SELF INSURED HEALTH/MEDICAL INSURANCE PROGRAM  
 ADMINISTRATIVE FEE  
 BASE PROPOSAL QUOTE FORM 2010/2011  
 (Must also submit bid on Reinsurance)**

**PLAN NAME** \_\_\_\_\_ **Broker** \_\_\_\_\_

Third Party Administrative costs shall be listed for each plan design proposed by the KCLC. KCLC will select the final plan and final copayment amounts. All administrative costs must be included.

Please provide a per month, per employee unit (inclusive of individual, family, spouse or child(ren) coverage) Third Party Administrative Cost/Fee:

*Preferred Provider Org. 100% in network 75% out of network (see current plan design)	\$ _____	IN NETWORK \$1,000 individual coinsurance maximum \$2,000 family coinsurance maximum No deductible
		OUT OF NETWORK
Guaranteed Discount Rate (in network claims)	\$ _____	\$2,500 individual coinsurance maximum \$5,000 family coinsurance maximum \$500 individual deductible \$1,000 family deductible
*HMO High plan 100% in network 0% out of network (see current plan design)	\$ _____	\$1,000 individual coinsurance maximum \$2,000 family coinsurance maximum No deductible
Guaranteed Discount Rate (in network claims)	\$ _____	
*HMO Low plan 80% in network 0% out of network (see current plan design)	\$ _____	\$2,500 individual coinsurance maximum \$5,000 family coinsurance maximum No deductible
Guaranteed Discount Rate (in network claims)	\$ _____	
*Medicare Supplement (see current plan design)	\$ _____	Including prescriptions
Guaranteed Discount Rate	\$ _____	

Would there be an administrative fee savings if the County limited itself to a single or two plan levels (base and high options)? If so, what would the respective administrative fees be for each plan listed above?

**EXHIBIT A1a**

**SELF INSURED HEALTH/MEDICAL INSURANCE PROGRAM**

**GUARANTEED RATES FOR 2ND AND/OR 3RD YEAR  
BASE PROPOSAL QUOTE FORM**

**PLAN NAME** \_\_\_\_\_ **Broker** \_\_\_\_\_

Please submit a guaranteed rate percentage for a second and third year of coverage. Reinsurance limits shall be calculated at a rate of 125% of claims for the preceding period of not less than 9 months and the maximum annual increase may not exceed 25%.

Please submit a guaranteed rate for a second and third year for third party administrative fees.

REINSURANCE -	Year 2011/2012	Year 2012/2013
Specific stop loss	_____%Minimum	_____%Minimum
	_____%Maximum	_____%Maximum
Aggregate stop loss	_____%Minimum	_____%Minimum
	_____%Maximum	_____%Maximum

**THIRD PARTY ADMINISTRATIVE FEE -**

	Year 2011/2012	Year 2012/2013
Employee unit	_____	_____
Guaranteed Discount Rate	_____%Minimum	_____%Minimum
	_____%Maximum	_____%Maximum

**EXHIBIT Aa**

**FULLY INSURED HEALTH/MEDICAL INSURANCE PROGRAM**

**GUARANTEED RATES FOR 2ND AND/OR 3RD YEAR  
BASE PROPOSAL QUOTE FORM**

**PLAN NAME** \_\_\_\_\_ **Broker** \_\_\_\_\_

Please submit a guaranteed rate percentage for a second and third year of coverage. The maximum annual increase may not exceed 25%.

	Year 2011/2012	Year 2012/2013
Employee	_____%Minimum	_____%Minimum
	_____%Maximum	_____%Maximum
Employee/Spouse	_____%Minimum	_____%Minimum
	_____%Maximum	_____%Maximum
Employee/Child(ren)	_____%Minimum	_____%Minimum
	_____%Maximum	_____%Maximum
Family	_____%Minimum	_____%Minimum
	_____%Maximum	_____%Maximum
Medigap (No Rx maximum)	_____%Minimum	_____%Minimum
	_____%Maximum	_____%Maximum
<b>ALTERNATIVE</b>		
Medigap (\$2,000 Rx max)	_____/_____%Minimum	_____/_____%Minimum
(\$3,000 Rx max)	_____/_____%Maximum	_____/_____%Maximum
<b>ADDITIONAL</b>		
Vision/hearing	_____%Minimum	_____%Minimum
	_____%Maximum	_____%Maximum

## BLUE CHOICE SCHEDULE OF BENEFITS

The next pages describe what's covered under your Blue Choice benefit plan. Please read through these pages to make sure you know what's covered. Knowing what's covered helps you get the most from your health plan.

**Many services have limits, copayments, deductibles or coinsurance. Benefits are also subject to the exclusions listed in the section, "What is Not Covered." Benefits and exclusions are described in the next sections. Please read the next sections.**

All payments are based on BCBSD's allowable charge. Any limits (such as days or dollar amounts) are combined for In-Network and Out-of-Network care. The combined limits determine when you reach the maximum.

### DEDUCTIBLE/

#### COINSURANCE

Plan Year Deductible

#### IN-NETWORK

None

#### OUT-OF-NETWORK

\$500 per person

\$1,000 per family

Plan Year Coinsurance

\$1,000 per person

\$2,000 per family

\$2,500 per person

\$5,000 per family

### SERVICE

#### Preventive Care

■ Well Baby Care

\$10 Copayment per visit

Not Covered

■ Routine Physical Exams

\$10 Copayment per visit

Not Covered

■ Routine GYN Exams

Primary medical doctor:

Not Covered

\$10 Copayment per visit

OB/GYN: \$20 Copayment per visit

■ Hemoglobin Tests

100% Covered

Not Covered

■ Cholesterol Tests

100% Covered

Not Covered

■ Blood Sugar Tests

100% Covered

Not Covered

■ Blood Antigen Tests

100% Covered

75% Covered

■ Lead Poison Screening Tests

100% Covered

75% Covered

■ Lab Charges for Pap Smear

100% Covered

75% Covered

■ Blood Occult

100% Covered

75% Covered

■ Routine Sigmoidoscopy

100% Covered

75% Covered

■ Colonoscopy

100% Covered

75% Covered

■ Barium Enema

100% Covered

75% Covered

■ Routine Mammogram

100% Covered

75% Covered

■ Routine Immunizations

\$10 Copayment per visit

75% Covered

■ Vision Exams

\$20 Copayment per visit

Not Covered

■ Hearing Exams

\$10 Copayment per visit

Not Covered

#### Hospital and Other Facility Benefits

■ Inpatient Hospital Care

100% Covered

75% Covered

■ Surgical Facility Care

100% Covered

75% Covered

■ Skilled Nursing Facilities

100% Covered; 120 day limit,  
benefits renew after 180 days  
without care.

75% Covered; 120 day limit,  
benefits renew after 180 days  
without care.

<b>SERVICE</b>	<b>IN-NETWORK BENEFIT</b>	<b>OUT-OF-NETWORK BENEFIT</b>
<b>Surgical - Medical Benefits</b>		
■ Surgical Care	100% Covered	75% Covered
■ Anesthesia	100% Covered	75% Covered
■ Inpatient Medical Care	100% Covered	75% Covered
<b>Maternity Benefits</b>		
■ Prenatal and Postnatal Care	100% Covered	75% Covered
■ Inpatient Hospital Care	100% Covered	75% Covered
■ Birthing Center	100% Covered	75% Covered
■ Obstetric Care	100% Covered	75% Covered
<b>Emergency Services</b>		
■ Emergency Ambulance and Paramedic Services	\$50 Copayment per occurrence	\$50 Copayment per occurrence
■ Emergency Facility	\$100 Copayment per visit (waived if admitted)	\$100 Copayment per visit (waived if admitted)
■ Medical Emergency Care (doctor's care in an emergency facility)	100% Covered	100% Covered; no deductible
<b>Therapeutic &amp; Diagnostic Services</b>		
<u>Outpatient Care</u>		
■ Chemotherapy, Radiation and Inhalation Therapy, Dialysis	100% Covered	75% Covered
■ Physical Therapy	\$20 Copayment per visit for up to 30 visits per plan year. Visits combine with Occupational Therapy visits	75% Copayment per visit for up to 30 visits per plan year. Visits combine with Occupational Therapy visits
■ Occupational Therapy	\$20 Copayment per visit for up to 30 visits per plan year. Visits combine with Physical Therapy visits	75% Copayment per visit for up to 30 visits per plan year. Visits combine with Physical Therapy visits
■ Speech Therapy	\$20 Copayment per visit for up to 30 visits per plan year.	75% Copayment per visit for up to 30 visits per plan year.
■ Cognitive Therapy	\$20 Copayment per visit for up to 30 consecutive days, beginning on the first day of treatment	75% Copayment per visit for up to 30 consecutive days, beginning on the first day of treatment
■ Cardiac Therapy	\$20 Copayment per visit for up to 3 sessions per week and 3 months of treatment	75% Copayment per visit for up to 3 sessions per week and 3 months of treatment
■ Lab, Imaging and Machine Tests	100% Covered	75% Covered
<u>Inpatient Care</u>		
■ Therapeutic Services	100% Covered	75% Covered
■ Diagnostic Services	100% Covered	75% Covered

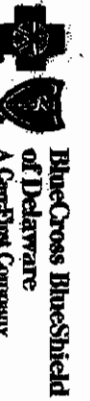
<b>SERVICE</b>	<b>IN-NETWORK BENEFIT</b>	<b>OUT-OF-NETWORK BENEFIT</b>
<b>Other Covered Services</b>		
■ Hospice	100% Covered for up to 240 days	75% Covered for up to 240 days
■ Home Health Care	100% Covered for up to 100 visits per plan year	75% Covered for up to 100 visits per plan year
■ Home Infusion	100% Covered	75% Covered
■ Inpatient Private Duty Nursing	100% Covered for up to 240 hours in 12 month period	75% Covered for up to 240 hours in 12 month period
■ Doctor's Home/Office Visits	\$10 Copayment per visit	75% Covered
■ Doctor's Nursing Home Visits	100% Covered	75% Covered
■ Specialist/Referral Care	\$20 Copayment per visit	75% Covered
■ Diabetic Education (limited to 6 visits within a three-year period)	\$20 Copayment per visit	75% Covered
■ Nutritional Counseling (limited to 6 visits per condition per plan year)	\$20 Copayment per visit	75% Covered
■ Allergy Tests	\$20 Copayment per visit	75% Covered
■ Allergy Treatment	Primary medical doctor: \$10 Copayment per visit Specialist: \$20 Copayment per visit	75% Covered
■ Chiropractic Care	\$20 Copayment per visit for up to 30 visits per plan year	75% Covered for up to 30 visits per plan year
■ Durable Medical Equipment	90% Covered for up to \$2,500 per person per plan year	75% Covered for up to \$2,500 per person per plan year
■ Care for Morbid Obesity	See Benefit Description	See Benefit Description
<b>Prescription Drugs</b>		
Per Prescription or Refill:	<b>34-DAY SUPPLY RETAIL</b>	<b>90-DAY SUPPLY MAIL ORDER</b>
■ Generic	\$10.00 Copayment	\$20.00 Copayment
■ Preferred Brand	\$25.00 Copayment	\$50.00 Copayment
■ Non-Preferred Brand	\$50.00 Copayment	\$100.00 Copayment

**NOTE:** If you choose a Preferred or Non-Preferred Brand Drug when a Generic Drug is available, even when your doctor indicates "Dispense as Written" on your prescription, you will have to pay the difference. To calculate the difference, take

- the charge for the Preferred or Non-Preferred Brand Drug
- less the charge for the Generic Drug
- plus the copayment for the Generic Drug
- which equals the amount you have to pay

**Mental Health and Substance Abuse Care**

	<b>AUTHORIZED CARE</b>	<b>UNAUTHORIZED CARE</b>
<u>Care for Serious Mental Illness and Authorized Substance Abuse Treatment</u>		
■ Inpatient and Partial Hospital/ Intensive Outpatient Care	100% Covered	Not Applicable
■ Outpatient Care (Office Visits)	\$20 Copayment per visit	Not Applicable
<u>Unauthorized Substance Abuse Treatment</u>		
■ Inpatient and Intensive Outpatient Care	Not Applicable	50% Covered <ul style="list-style-type: none"> <li>■ Limited to 31 inpatient days or 62 outpatient days per Treatment Period. Limit of one 270-day Treatment Period per lifetime.</li> <li>■ Two outpatient days reduce inpatient days by one day; one inpatient day reduces outpatient days by 2 days.</li> </ul>
■ Outpatient Care (Office Visits)	Not Applicable	Not Covered
<u>Care for Other Mental Health Disorders</u>		
■ Inpatient Mental Health/Partial Hospitalization Care <ul style="list-style-type: none"> <li>■ Limited to 31 inpatient days or 62 partial hospitalization days per plan year.</li> <li>■ One inpatient day reduces partial hospitalization days by two days; two days of partial hospitalization reduce inpatient days by one day.</li> </ul>	80% Covered; subject to the In-Network Coinsurance Expense Limit	50% Covered; subject to the Out-of-Network Deductible and Coinsurance Expense Limit
■ Outpatient Mental Health Care <ul style="list-style-type: none"> <li>■ Limited to 20 visits per plan year.</li> </ul>	80% Covered; subject to the In-Network Coinsurance Expense Limit	50% Covered; subject to the Out-of-Network Deductible and Coinsurance Expense Limit



**A SUMMARY OF BLUE CHOICE®  
PREFERRED PROVIDER ORGANIZATION - 90/70 BENEFITS  
FOR KENT COUNTY LEVY COURT**

SERVICE	IN NETWORK	OUT OF NETWORK
<b>PREVENTIVE MEDICAL SERVICES</b>		
■ Periodic Physical Exams	100% covered	70% covered
■ Routine Annual GYN Exam	100% covered	70% covered
■ Routine Mammogram	100% covered	70% covered
■ Routine Sigmoidoscopy & Colonoscopy	100% covered	70% covered
■ Routine Pap Smear ( <i>Lab charges</i> )	100% covered	70% covered
■ Routine Well-Child Care	100% covered	70% covered
■ Immunizations	100% covered	70% covered
■ Periodic Vision Exams	100% covered	Not covered
■ Periodic Hearing Exams	100% covered	70% covered
■ Prostate Screening Antigen Test ( <i>Lab charges</i> )	100% covered	70% covered
■ Lead Poisoning Screening Test ( <i>Lab charges</i> )	100% covered	70% covered
<b>TREATMENT OF ILLNESS OR INJURY</b>		
■ Doctor's Office Visit for Diagnosis & Treatment	90% covered <sup>1</sup>	70% covered <sup>2</sup>
■ Specialist/Referral Care	90% covered <sup>1</sup>	70% covered <sup>2</sup>
■ Allergy Testing	90% covered <sup>1</sup>	70% covered <sup>2</sup>
■ Allergy Treatment	90% covered <sup>1</sup>	70% covered <sup>2</sup>
■ Laboratory Services	90% covered <sup>1</sup>	70% covered <sup>2</sup>
■ Imaging & Machine Testing Services	90% covered <sup>1</sup>	70% covered <sup>2</sup>
■ Physical & Occupational Therapy	90% covered <sup>1</sup> for up to 30 combined visits per plan year	70% covered <sup>2</sup> for up to 30 combined visits per plan year
■ Speech Therapy	90% covered <sup>1</sup> for up to 30 visits per plan year	70% covered <sup>2</sup> for up to 30 visits per plan year
■ Radiation Therapy & Chemotherapy	90% covered <sup>1</sup>	70% covered <sup>2</sup>
■ Home/Nursing Home Visits	90% covered <sup>1</sup>	70% covered <sup>2</sup>
■ Chiropractic	90% covered <sup>1</sup> for up to 30 visits per plan year	70% covered <sup>2</sup> for up to 30 visits per plan year
<b>IN THE HOSPITAL</b>		
■ Semiprivate Room & Board (including intensive care, if medically appropriate)	90% covered <sup>1</sup>	70% covered <sup>2</sup>

G: Maintaining Reasonable Files/Benefit Comparisons/KCLC PPO 90/70 (6/27/09)

**A SUMMARY OF BLUE CHOICE®  
PREFERRED PROVIDER ORGANIZATION 9070 BENEFITS  
FOR KENT COUNTY LEVY COURT (CONT.)**

	IN-NETWORK	OUT-OF-NETWORK
<b>PHYSICIANS &amp; SURGEONS SERVICES</b>	90% covered <sup>1</sup>	70% covered. <sup>2</sup>
■ Physicians & Surgeons Services	90% covered <sup>1</sup>	70% covered. <sup>2</sup>
■ Other Medical Professional Services	90% covered <sup>1</sup>	70% covered. <sup>2</sup>
<b>SURGERY</b>		
■ Outpatient	90% covered <sup>1</sup>	70% covered <sup>2</sup>
<b>MATERNITY</b>		
■ Prenatal & Postnatal Care	90% covered <sup>1</sup>	70% covered. <sup>2</sup>
■ Delivery: Hospital	90% covered <sup>1</sup>	70% covered. <sup>2</sup>
■ Delivery: Physician	90% covered <sup>1</sup>	70% covered. <sup>2</sup>
■ Birthing Center	90% covered <sup>1</sup>	70% covered. <sup>2</sup>
<b>EMERGENCY SERVICES</b>		
■ Physician's Office	90% covered <sup>1</sup>	70% covered. <sup>2</sup>
■ Hospital and Outpatient Emergency Facilities	90% covered <sup>1</sup>	70% covered. <sup>2</sup>
<b>AMBULANCE</b>	90% covered <sup>1</sup>	70% covered <sup>2</sup>
<b>OTHER SERVICES</b>		
■ Inpatient Private Duty Nursing	90% covered <sup>1</sup> for up to 240 hours in 12-month period.	70% covered <sup>2</sup> for up to 240 hours in 12-month period.
Prosthetic Devices and Durable Medical Equipment	90% covered <sup>1</sup>	70% covered. <sup>2</sup>
■ Skilled Nursing Facility	90% covered <sup>1</sup> for up to 120 days per confinement.	70% covered <sup>2</sup> for up to 120 days per confinement.
■ Home Health Care	90% covered <sup>1</sup> for up to 100 visits per plan year.	70% covered <sup>2</sup> for up to 100 visits per plan year.
<b>ALCOHOL AND DRUG ABUSE TREATMENT</b>	<b>ALTHORIZED</b> Same as Other Medical Care.	<b>NON-ALTHORIZED</b> 70% covered <sup>2</sup> for up to 31 inpatient days or 62 outpatient days per treatment period. Maximum of one treatment period per lifetime. Two outpatient days reduce inpatient days by 1 day; one inpatient day reduces outpatient days by 2 days

**A SUMMARY OF BLUE CHOICE®  
PREFERRED PROVIDER ORGANIZATION 90/70 BENEFITS  
FOR KENT COUNTY LEVY COURT (CONT.)**

<b>SERIOUS MENTAL HEALTH CARE</b>		
■ Inpatient and Partial Hospitalization	Same as Other Medical Care.	Same as Other Medical Care.
■ Outpatient	Same as Other Medical Care.	Same as Other Medical Care.
<b>OTHER MENTAL HEALTH CARE</b>		
■ Inpatient and Partial Hospitalization	90% covered <sup>1</sup> for up to 31 inpatient days or 62 partial hospitalization days per plan year. One inpatient day reduces partial hospitalization days by two days; two partial hospitalization days reduce inpatient days by one day.	70% covered <sup>2</sup> for up to 31 inpatient days or 62 partial hospitalization days per calendar year. One inpatient day reduces partial hospitalization days by two days; two partial hospitalization days reduce inpatient days by one day.
■ Outpatient	90% <sup>1</sup> covered for up to 20 visits per plan year.	70% covered <sup>2</sup> for up to 20 visits per plan year.

<b>PRESCRIPTION DRUGS</b> (Per Prescription or Retail)	<b>30-DAY SUPPLY RETAIL</b>	<b>90-DAY SUPPLY MAIL ORDER</b>
■ Generic	\$ 10.00 Copayment	\$ 20.00 Copayment
■ Preferred Brand	\$ 25.00 Copayment	\$ 50.00 Copayment
■ Non-Preferred Brand	\$ 50.00 Copayment	\$ 100.00 Copayment

In-Network benefits are subject to a plan year deductible of \$500 per person (\$1,000 per family). Two individuals must meet the deductible in order for the family deductible to be met. Benefits are then covered at the indicated percentage for that service until the coinsurance totals \$1,500 per person (\$3,000 per family). Two individuals must meet the coinsurance expense limit in order for benefits to be paid at 100% of the allowable charge for the rest of the family members.

2 Out-of-Network benefits are subject to a calendar year deductible of \$1000 per person (\$2000 per family). Two individuals must meet the deductible in order for the family deductible to be met. Benefits are then covered at the indicated percentage for that service until the coinsurance totals \$3,000 per person (\$6,000 per family). Two individuals must meet the coinsurance expense limit in order for benefits to be paid at 100% of the allowable charge for the rest of the family members.

Full contract benefits are contingent upon following the guidelines of the Managed Care Program. In addition, mental health and substance abuse care must be authorized in advance by the Case Management Center and provided by an authorized provider to receive full contract benefits.

Payments for In-Network or Out-of-Network services that are subject to day or dollar limits are combined to determine when that limit is met.

**A SUMMARY OF BLUE CHOICE®  
PREFERRED PROVIDER ORGANIZATION 90/70 BENEFITS  
FOR KENT COUNTY LEVY COURT (CONT.)**

All percentages listed above apply to Blue Cross Blue Shield of Delaware's maximum allowable charge. When calculating deductible or coinsurance expenses, only the allowable charges are considered.

This is not a contract. This benefit comparison is intended to provide you with a general overview of these Blue Cross Blue Shield of Delaware health benefit program.

Blue Cross Blue Shield of Delaware and Carefirst, Inc., are independent licensees of the Blue Cross and Blue Shield Association.

## HMO-100

**BLUE CARE SCHEDULE OF BENEFITS**

The next pages describe what's covered under your Blue Care benefits. Please read through these pages to make sure you know what's covered. Knowing what's covered helps you get the most from your health plan.

**Many services have limits, copayments or coinsurance. Benefits are also subject to the exclusions listed in the section, "What is Not Covered." Benefits and exclusions are described in the next sections. Please read the next sections.**

All payments are based on BCBSD's allowable charge.

Plan Year Coinsurance Expense Limit	\$1,000 per person \$2,000 per family
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**SERVICE****BENEFIT****Preventive and Primary Care Services**

■ Well Baby Care	\$10 Copayment per visit
■ Routine Physical Exams	\$10 Copayment per visit
■ Routine GYN Exams	By PCP: \$10 Copayment per visit By OB/GYN: \$20 Copayment per visit
■ Hemoglobin Tests	100% Covered
■ Cholesterol Tests	100% Covered
■ Blood Sugar Tests	100% Covered
■ Blood Antigen Tests	100% Covered
■ Lead Poison Screening Tests	100% Covered
■ Lab Charge for Pap Smear	100% Covered
■ Blood Occult	100% Covered
■ Routine Sigmoidoscopy	\$10 Copayment per visit
■ Colonoscopy	\$10 Copayment per visit
■ Barium Enema	\$10 Copayment per visit
■ Routine Mammogram	\$10 Copayment per visit
■ Routine Immunizations	\$10 Copayment per visit
■ Routine Vision Exams	\$20 Copayment per visit
■ Routine Hearing Exams	\$10 Copayment per visit
■ Doctor's Home/Office Visits	\$10 Copayment per visit
■ Doctor's Nursing Home Visits	\$20 Copayment per visit

**Hospital and Other Facility Benefits**

■ Inpatient Hospital Care	100% Covered
■ Outpatient Surgical Facilities	100% Covered
■ Skilled Nursing Facilities	100% Covered; 120 day limit, benefits renew after 180 days without care

**Surgical-Medical Benefits**

■ Surgical Care	100% Covered
■ Anesthesia Care	100% Covered
■ Inpatient Medical Care	100% Covered

<b>SERVICE</b>	<b>BENEFIT</b>
<b>Maternity Benefits</b>	
■ Prenatal and Postnatal Care	100% Covered
■ Inpatient Hospital Care	100% Covered
■ Birthing Center	100% Covered
■ Obstetric Care	100% Covered
<b>Emergency Services</b>	
■ Emergency Ambulance and Paramedic Services	\$50 Copayment per occurrence
■ Emergency Facility	\$100 Copayment per visit
■ Medical Emergency Care (doctor's care in an emergency facility)	100% Covered
<b>Therapeutic &amp; Diagnostic Services</b>	
<u>Outpatient Care</u>	
■ Chemotherapy, Radiation and Inhalation Therapy, Dialysis	100% Covered
■ Physical Therapy	80% Covered for up to 30 visits per plan year. Visits combine with Occupational Therapy visits
■ Occupational Therapy	80% Covered for up to 30 visits per plan year. Visits combine with Physical Therapy visits
■ Speech Therapy	80% Covered for up to 30 visits per plan year.
■ Cognitive Therapy	80% Covered for up to 30 consecutive days, beginning on the first day of treatment
■ Cardiac Therapy	80% Covered for up to 3 sessions per week and 3 months of treatment
■ Lab Tests	100% Covered
■ Imaging and Machine Tests	100% Covered
<u>Inpatient Care</u>	
■ Therapeutic Services	100% Covered
■ Diagnostic Services	100% Covered
<b>Other Covered Services</b>	
■ Hospice	100% Covered for up to 240 days
■ Home Health Care	100% Covered for up to 100 visits per plan year
■ Home Infusion	100% Covered
■ Inpatient Private Duty Nursing	100% Covered for up to 240 hours in 12 month period
■ Specialist/Referral Care	\$20 Copayment per visit
■ Diabetic Education (limited to 6 visits within a three-year period)	\$20 Copayment per visit
■ Nutritional Counseling (limited to 6 visits per condition per plan year)	\$20 Copayment per visit
■ Allergy Tests	\$20 Copayment per visit
■ Allergy Treatment	By PCP: \$10 Copayment per visit By Specialist: \$20 Copayment per visit
■ Durable Medical Equipment	90% Covered; \$2,500 per person benefit maximum per plan year
■ Chiropractic Care	\$20 Copayment per visit for up to 30 visits per plan year
■ Care for Weight Loss	See Benefit Description

**SERVICE**

**BENEFIT**

**Prescription Drugs**

Per Prescription or Refill:

- 34-Day Supply Retail
  - Generic \$10.00 Copayment
  - Preferred Brand \$25.00 Copayment
  - Non-Preferred Brand \$50.00 Copayment
- 90-Day Supply Mail Order
  - Generic \$20.00 Copayment
  - Preferred Brand \$50.00 Copayment
  - Non-Preferred Brand \$100.00 Copayment

**NOTE:** If you choose a Preferred or Non-Preferred Brand Drug when a Generic Drug is available, even when your doctor indicates "Dispense as Written" on your prescription, you will have to pay the difference. To calculate the difference, take

- the charge for the Preferred or Non-Preferred Brand Drug
- less the charge for the Generic Drug
- plus the copayment for the Generic Drug
- which equals the amount you have to pay

**Mental Health and Substance Abuse Benefits**

Care for Serious Mental Illness and Substance Abuse Treatment

- Inpatient and Partial Hospital/Intensive Outpatient Care 100% Covered
- Outpatient Care (Office Visits) \$20 Copayment per visit

Care for Other Mental Health Disorders

- Inpatient and Partial Hospital Care 80% Covered
  - Limited to 31 inpatient days or 62 partial hospitalization days per plan year.
  - One inpatient day reduces partial hospitalization days by two days; two days of partial hospitalization reduce inpatient days by one day.
- Outpatient Care (Office Visits) \$20 Copayment per visit
  - Limited to 20 visits per plan year

## COPAYMENTS AND COINSURANCE

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### COPAYMENTS

A copayment is an amount you pay at the time you have care. After the copayment, care is paid at 100%. Copayments apply only to certain services. See the Schedule of Benefits for a list of services with copayments.

Here's how copayments work:

- You pay only one copayment to the same provider in the same day.
- If you see more than one provider the same day, you pay copayments to each provider.
- If you have more than one prescription filled the same day, you pay copayments for each prescription.

**Copayments should be paid at the time you receive care.**

### COINSURANCE EXPENSE LIMIT

Some of your benefits are paid at 80% of the allowable charge. This means the difference of 20% is your coinsurance. Your benefits have a \$1,000 coinsurance expense limit per person. This applies when the coinsurance adds up to \$1,000. Then, we pay 100% for the rest of the year. The 100% is based on the allowable charge.

You have a \$2,000 **family** coinsurance expense limit. This applies when two members each meet their \$1,000 coinsurance expense limit (totaling \$2,000). Then, we pay 100% for all members for the rest of the year. The 100% is based on the allowable charge.

Note: The following are not included in your coinsurance expense limit:

- copayments

#### HOW COINSURANCE WORKS

Your coinsurance is 20% ( $100\% - 80\% = 20\%$ ). Suppose you have medical expenses of \$500 in allowable charges. Here's how your coinsurance expense limit is reduced:

Your coinsurance expense limit is .....	\$1,000
Less: Your coinsurance times the medical expenses ( $20\% \times \$500$ ) .....	\$100
Equals: The amount of coinsurance you still have to pay to meet your coinsurance expense limit:.....	\$900

When you meet your coinsurance expense limit, benefits are paid at 100% for the rest of the plan year.

## BLUE CARE SCHEDULE OF BENEFITS

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The next pages describe what's covered under your Blue Care benefits. Please read through these pages to make sure you know what's covered. Knowing what's covered helps you get the most from your health plan.

**Many services have limits, copayments or coinsurance. Benefits are also subject to the exclusions listed in the section, "What is Not Covered." Benefits and exclusions are described in the next sections. Please read the next sections.**

All payments are based on BCBSD's allowable charge.

Plan Year Coinsurance Expense Limit	\$2,500 per person \$5,000 per family
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### SERVICE

### BENEFIT

#### Preventive and Primary Care Services

■ Well Baby Care	\$15 Copayment per visit
■ Routine Physical Exams	\$15 Copayment per visit
■ Routine GYN Exams	By PCP: \$15 Copayment per visit By OB/GYN: \$30 Copayment per visit
■ Hemoglobin Tests	100% Covered
■ Cholesterol Tests	100% Covered
■ Blood Sugar Tests	100% Covered
■ Blood Antigen Tests	100% Covered
■ Lead Poison Screening Tests	100% Covered
■ Lab Charge for Pap Smear	100% Covered
■ Blood Occult	100% Covered
■ Routine Sigmoidoscopy	\$15 Copayment per visit
■ Colonoscopy	\$15 Copayment per visit
■ Barium Enema	\$15 Copayment per visit
■ Routine Mammogram	\$15 Copayment per visit
■ Routine Immunizations	\$15 Copayment per visit
■ Routine Vision Exams	\$30 Copayment per visit
■ Routine Hearing Exams	\$15 Copayment per visit
■ Doctor's Home/Office Visits	\$15 Copayment per visit
■ Doctor's Nursing Home Visits	\$30 Copayment per visit

#### Hospital and Other Facility Benefits

■ Inpatient Hospital Care	80% Covered
■ Outpatient Surgical Facilities	80% Covered
■ Skilled Nursing Facilities	80% Covered; 120 day limit, benefits renew after 180 days without care

#### Surgical-Medical Benefits

■ Surgical Care	80% Covered
■ Anesthesia Care	80% Covered
■ Inpatient Medical Care	80% Covered

## **SERVICE**

### **Maternity Benefits**

- Prenatal and Postnatal Care
- Inpatient Hospital Care
- Birthing Center
- Obstetric Care

### **Emergency Services**

- Emergency Ambulance and Paramedic Services
- Emergency Facility
- Medical Emergency Care (doctor's care in an emergency facility)

### **Therapeutic & Diagnostic Services**

#### **Outpatient Care**

- Chemotherapy, Radiation and Inhalation Therapy, Dialysis
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Cognitive Therapy
- Cardiac Therapy
- Lab Tests
- Imaging and Machine Tests

#### **Inpatient Care**

- Therapeutic Services
- Diagnostic Services

### **Other Covered Services**

- Hospice
- Home Health Care
- Home Infusion
- Inpatient Private Duty Nursing
- Specialist/Referral Care
- Diabetic Education (limited to 6 visits within a three-year period)
- Nutritional Counseling (limited to 6 visits per condition per plan year)
- Allergy Tests
- Allergy Treatment
- Durable Medical Equipment
- Chiropractic Care
- Care for Weight Loss

## **BENEFIT**

80% Covered  
80% Covered  
80% Covered  
80% Covered

\$50 Copayment per occurrence

\$100 Copayment per visit (waived if admitted)  
100% Covered

80% Covered

60% Covered for up to 30 visits per plan year. Visits combine with Occupational Therapy visits.

60% Covered for up to 30 visits per plan year. Visits combine with Physical Therapy visits.

60% Covered for up to 30 visits per plan year.

60% Covered for up to 30 consecutive days, beginning on the first day of treatment

60% Covered for up to 3 sessions per week and 3 months of treatment

\$10 Copayment per visit

80% Covered

80% Covered

80% Covered

80% Covered for up to 240 days

80% Covered for up to 100 visits per plan year

80% Covered

80% Covered for up to 240 hours in 12 month period

\$30 Copayment per visit

\$30 Copayment per visit

\$30 Copayment per visit

\$30 Copayment per visit

By PCP: \$15 Copayment per visit

By Specialist: \$30 Copayment per visit

50% Covered

\$30 Copayment per visit for up to 30 visits per plan year

See Benefit Description

**SERVICE**

**BENEFIT**

**Prescription Drugs**

Per Prescription or Refill:

- 34-Day Supply Retail
  - Generic \$10.00 Copayment
  - Preferred Brand \$25.00 Copayment
  - Non-Preferred Brand \$50.00 Copayment
- 90-Day Supply Mail Order
  - Generic \$20.00 Copayment
  - Preferred Brand \$50.00 Copayment
  - Non-Preferred Brand \$100.00 Copayment

**NOTE:** If you choose a Preferred or Non-Preferred Brand Drug when a Generic Drug is available, even when your doctor indicates "Dispense as Written" on your prescription, you will have to pay the difference. To calculate the difference, take

- the charge for the Preferred or Non-Preferred Brand Drug
- less the charge for the Generic Drug
- plus the copayment for the Generic Drug
- which equals the amount you have to pay

**Mental Health and Substance Abuse Benefits**

Care for Serious Mental Illness and Substance Abuse Treatment

- Inpatient and Partial Hospital/Intensive Outpatient Care 80% Covered
- Outpatient Care (Office Visits) \$30 Copayment per visit

Care for Other Mental Health Disorders

- Inpatient and Partial Hospital Care 50% Covered
  - Limited to 31 inpatient days or 62 partial hospitalization days per plan year.
  - One inpatient day reduces partial hospitalization days by two days; two days of partial hospitalization reduce inpatient days by one day.
- Outpatient Care (Office Visits) \$30 Copayment per visit
  - Limited to 20 visits per plan year.

## COPAYMENTS AND COINSURANCE

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### COPAYMENTS

A copayment is an amount you pay at the time you have care. After the copayment, care is paid at 100%. Copayments apply only to certain services. See the Schedule of Benefits for a list of services with copayments.

Here's how copayments work:

- You pay only one copayment to the same provider in the same day.
- If you see more than one provider the same day, you pay copayments to each provider.
- If you have more than one prescription filled the same day, you pay copayments for each prescription.

**Copayments should be paid at the time you receive care.**

### COINSURANCE EXPENSE LIMIT

Many of your benefits are paid at 80% of the allowable charge. This means the difference of 20% is your coinsurance. Your benefits have a \$2,500 coinsurance expense limit per person. This applies when the coinsurance adds up to \$2,500. Then, we pay 100% for the rest of the year. The 100% is based on the allowable charge.

You have a \$5,000 **family** coinsurance expense limit. This applies when two members each meet their \$2,500 coinsurance expense limit (totaling \$5,000). Then, we pay 100% for all members for the rest of the year. The 100% is based on the allowable charge.

Note: The following are not included in your coinsurance expense limit:

- copayments

### HOW COINSURANCE WORKS

Your coinsurance is 20% (100% - 80% = 20%). Suppose you have medical expenses of \$1,000 in allowable charges. Here's how your coinsurance expense limit is reduced:

Your coinsurance expense limit is .....	\$2,500
Less: Your coinsurance times the medical expenses (20% X \$1,000) .....	\$200
Equals: The amount of coinsurance you still have to pay to meet your coinsurance expense limit:.....	\$2,300

When you meet your coinsurance expense limit, benefits are paid at 100% for the rest of the plan year.

## MED. SUPPLEMENT

## INPATIENT HOSPITAL &amp; OTHER FACILITY BENEFITS

<b>Benefit:</b>		<b>Medicare Covers:</b>	<b>Special Medicfill Covers:</b>	<b>You Pay:</b>
Inpatient Days in Acute Hospitals; Semi-Private Room and Ancillary Services (for covered expenses each benefit period)	Days 1-60	Medicare pays all but the Medicare Part A deductible.	This plan covers the Medicare Part A deductible.	You pay nothing.
	Days 61-90	Medicare pays all but a specified dollar amount of coinsurance per day.	This plan covers a specified dollar amount of coinsurance.	You pay nothing.
	Days 91-120	Medicare pays nothing. (There are 60 Lifetime Reserve Days* with all but the daily coinsurance amount covered. These days may be used at the patient's discretion.)	This plan covers inpatient care for days 91 through 120 in a general hospital except for mental and nervous treatment. These days may be used before Medicare's 60 lifetime reserve days. If the lifetime reserve days are used, the plan covers the coinsurance amount.	You pay nothing.
	Days 121-365	Medicare pays nothing.	This plan covers inpatient care for days 121 through 365, except for mental and nervous treatment. These days may be used before Medicare's 60 lifetime reserve days. If the lifetime reserve days are used, the plan covers the coinsurance amount.	You pay nothing.

\*Medicare's 60 Lifetime Reserve Days may be used only once; they are not renewable.

## INPATIENT HOSPITAL & OTHER FACILITY BENEFITS (CON'T)

<b>Benefit:</b>		<b>Medicare Covers:</b>	<b>Special Medicfill Covers:</b>	<b>You Pay:</b>
Treatment for Mental or Nervous Disorders (in a Psychiatric Hospital)		Benefits are limited to 190 days for your lifetime. Medicare covers all but the Medicare Part A deductible and the specified coinsurance for days 61-120	This plan covers the Medicare Part A deductible and the specified dollar amount of coinsurance for up to the 190 lifetime days approved by Medicare.	You pay nothing while Medicare is paying. You pay all charges thereafter.
Inpatient Dental Surgery		Medicare covers hospital services for surgery related to the jaw or reduction of any fracture of the jaw or facial bone.	This plan covers the Medicare Part A deductible and specified dollar amount of coinsurance when Medicare standards are met.	You pay nothing.
Services in a Medicare Approved Skilled Nursing Facility	Days 1-20	Medicare pays 100% of eligible expenses.	This plan pays nothing.	You pay nothing.
	Days 21-100	Medicare pays all but a specified dollar amount of coinsurance per day.	This plan pays a specified dollar amount of coinsurance per day.	You pay nothing

**INPATIENT HOSPITAL & OTHER FACILITY BENEFITS (CON'T)**

<b>Benefit:</b>	<b>Medicare Covers:</b>	<b>Special Medicfill Covers:</b>	<b>You Pay:</b>
Coverage Outside of the United States	Generally, Medicare does not pay for services provided outside the U.S.	When Medicare standards are met, and Medicare pays, this plan covers the Part A deductible and coinsurance for the first 90 days and then 100% of the allowable charge for days 91-120.  If the admission does not qualify for payment under Medicare, but if it meets Medicare criteria for an inpatient admission within the United States, we will pay for services as defined by Medicare Law for 120 days of inpatient care.	You pay nothing.  You pay nothing for the first 120 days if the hospital confinement is approved for payment by BCBSD. You pay all charges thereafter.

### OUTPATIENT HOSPITAL BENEFITS

<b>Benefit:</b>	<b>Medicare Covers:</b>	<b>Special Medicfill Covers:</b>	<b>You Pay:</b>
<ul style="list-style-type: none"> <li>■ Anesthesia</li> <li>■ Clinical Services</li> <li>■ Emergency Accident</li> <li>■ Dialysis</li> <li>■ Injections (except most routine immunizations)</li> <li>■ Laboratory</li> <li>■ Machine Testing</li> <li>■ Medical Emergency</li> <li>■ Minor Surgery</li> <li>■ Physical Therapy</li> <li>■ Radiation Therapy</li> <li>■ Imaging Services</li> </ul>	Medicare covers 80% of the Reasonable Charges** after the Medicare Part B deductible.	This plan covers the Medicare Part B deductible and 20% of the Reasonable Charges**.	You pay nothing.
Home Health Visits	Covered at 100% of the Reasonable Charge**, subject to Medicare criteria.	There is no coverage under this plan for Home Health Visits.	You pay charges, if any, for services not covered by Medicare.
Coverage Outside of the United States	Generally, Medicare does not pay for services provided outside the U.S.	<p>When Medicare pays, this plan covers hospital benefits equivalent to Medicare hospital benefits in the U.S., including the payment of the deductible and coinsurance amounts.</p> <p>When Medicare does not pay, payment will be made for those covered services as defined by Medicare. Payment must be approved by BCBSD</p>	You pay nothing.

\*\*Reasonable Charge means the amount approved by the Medicare carrier as the allowable charge for reimbursement under the Medicare program. If the medical care provider does not accept Medicare assignment, you may be responsible for the amount the charges exceed Medicare's reasonable charge.

**SURGICAL-MEDICAL BENEFITS**

<b>Benefit:</b>	<b>Medicare Covers:</b>	<b>Special Medicfill Covers:</b>	<b>You Pay:</b>
<ul style="list-style-type: none"> <li>■ Ambulance</li> <li>■ Anesthesia</li> <li>■ Appliances</li> <li>■ Chiropractic Services (subject to Medicare criteria)</li> <li>■ Clinic Visits</li> <li>■ Durable Medical Equipment</li> <li>■ Home &amp; Office Visits</li> <li>■ Imaging Services</li> <li>■ Inpatient Consultants</li> <li>■ Inpatient Medical Visits</li> <li>■ Inpatient Professional Services</li> <li>■ Inpatient Skilled Nursing Facility Visits</li> <li>■ Laboratory</li> <li>■ Machine Testing</li> <li>■ Medical Emergency Care</li> <li>■ Physical Therapy</li> <li>■ Occupational &amp; Speech Therapy</li> <li>■ Radiation Therapy</li> <li>■ Surgery</li> </ul>	<p>Medicare covers 80% of the Reasonable Charges** after the Medicare Part B deductible.</p>	<p>This plan covers the Medicare Part B deductible and 20% of the Reasonable Charges.**</p>	<p>You pay nothing.</p>

\*\*Reasonable Charge means the amount approved by the Medicare carrier as the allowable charge for reimbursement under the Medicare program. If the medical care provider does not accept Medicare assignment, you may be responsible for the amount the charges exceed Medicare's reasonable charge.

**SURGICAL-MEDICAL BENEFITS (CON'T)**

<b>Benefit:</b>	<b>Medicare Covers:</b>	<b>Special Medicfill Covers:</b>	<b>You Pay:</b>
Outpatient Treatment for Mental and Nervous Disorders	Medicare covers 50% of the Reasonable Charges** accepted by Medicare after the Medicare Part B deductible. If services are rendered in a partial hospitalization program or in the outpatient department of a hospital, Medicare covers 80% of the Reasonable Charges** after the Medicare Part B deductible.	This plan covers the Medicare Part B deductible and 50% or 20% of the Reasonable Charges**, whichever is applicable.	You pay nothing.
Coverage Outside of the United States	Generally, Medicare does not pay for services provided outside the U.S.	When Medicare pays, this plan covers the Medicare Part B deductible and 20% coinsurance.  When Medicare does not pay, benefits are covered at 20% of the BCBSD allowable.	You pay nothing.  You pay all charges over 20% of the BCBSD allowable.

\*\*Reasonable Charge means the amount approved by the Medicare carrier as the allowable charge for reimbursement under the Medicare program. If the medical care provider does not accept Medicare assignment, you may be responsible for the amount the charges exceed Medicare's reasonable charge.

**PREVENTIVE BENEFITS**

<b>Benefit:</b>	<b>Medicare Covers:</b>	<b>Special Medicfill Covers:</b>	<b>You Pay:</b>
<p><b>Note:</b> The following is a list of preventive services provided by Medicare that are supplemented by this plan. Some services are subject to coinsurance only, while others are subject to the Part B deductible and coinsurance. Medicare also pays for other preventive services (for example, flu shots and diabetes and cardiovascular screenings) that are not subject to either the Part B deductible or coinsurance, and that are not listed below. See the <i>Medicare and You</i> information manual for information about these services.</p> <p>‘Welcome to Medicare’ Physical Exam (covered only within the first six months of your Part-B enrollment)</p>	<p>Medicare pays 80% of Medicare Eligible expenses after the Part B deductible for a one-time review of your health, including certain screenings and shots, and if needed, referrals for other care.</p>	<p>When Medicare pays, this plan covers the Medicare Part B deductible and 20% coinsurance.</p>	<p>You pay nothing.</p>
<p>Abdominal Aortic Aneurysm Screening</p>	<p>Medicare pays 80% of the Medicare Eligible expenses, with no Part B deductible requirement, for a one-time screening ultrasound if you are at risk, only if you are referred for the screening as a result of the ‘Welcome to Medicare’ Physical Exam.</p>	<p>This plan covers 20% of Medicare Eligible expenses.</p>	<p>You pay nothing.</p>
<p>Annual Routine Mammogram</p>	<p>Medicare pays 80% of Medicare Eligible expenses, with no Part B deductible requirement, for annual mammograms for women age 40 and over.</p>	<p>This plan covers 20% of Medicare Eligible expenses.</p>	<p>You pay nothing.</p>
<p>Pap Smear</p>	<p>Medicare pays 100% of Medicare Eligible expenses, with no Part B deductible requirement, for Pap smears once every 24 months for women at average risk, and once every twelve months for women at high risk.</p>	<p>When Pap smears for cancer screening are covered by Medicare, this plan pays nothing. When not covered by Medicare, this plan will pay 100% of our allowable charges for one Pap smear every 12 months.</p>	<p>You pay nothing.</p>

**PREVENTIVE BENEFITS (CON'T)**

<b>Benefit:</b>	<b>Medicare Covers:</b>	<b>Special Medicfill Covers:</b>	<b>You Pay:</b>
Pap collection, Pelvic Exams and Breast Exams	Medicare pays 80% of Medicare Eligible expenses, with no Part B deductible requirement once every 24 months for women at average risk, and once every twelve months for women at high risk.	This plan covers 20% of Medicare Eligible expenses.	You pay nothing.
Glaucoma Tests	Medicare pays 80% of Medicare Eligible expenses after the Part B deductible for annual glaucoma tests for persons who are at high risk for glaucoma, including diabetics and those with a family history of glaucoma.	When Medicare pays, this plan covers the Medicare Part B deductible and 20% coinsurance.	You pay nothing.
Colorectal Cancer Screening	<p>Medicare pays 80% of Medicare Eligible expenses with no Part B deductible requirement for:</p> <ul style="list-style-type: none"> <li>■ flexible sigmoidoscopy every 48 months for covered persons age 50 and over who are at average risk; and</li> <li>■ colonoscopy every 2 years for those covered persons who are at high risk, and</li> <li>■ barium enema – Once every 48 months if age 50 or older when used instead of a sigmoidoscopy or colonoscopy</li> </ul>	When services are covered by Medicare, this plan covers 20% of Medicare Eligible expenses.	You pay nothing.

**PREVENTIVE BENEFITS (CON'T)**

<b><u>Benefit:</u></b>	<b><u>Medicare Covers:</u></b>	<b><u>Special Medicfill Covers:</u></b>	<b><u>You Pay:</u></b>
Bone Mass Measurement	Medicare pays 80% of Medicare Eligible expenses after the Part B deductible for bone mass measurement tests for persons who are at high risk for broken bones.	When Medicare pays, this plan covers the Medicare Part B deductible and 20% coinsurance.	You pay nothing.

### OTHER COVERED BENEFITS

<b>Benefit:</b>	<b>Medicare Covers:</b>	<b>Special Medicfill Covers:</b>	<b>You Pay:</b>
Outpatient Prescription Drugs	Medicare does not cover most outpatient prescription drugs.	This plan covers the cost of prescription drugs except for the copayment.	<p>You pay the copayment per prescription or refill as follows:</p> <p><u>Retail:</u>            Generic: \$10.00            Preferred Brand: \$20.00            Non-Preferred Brand: \$40.00</p> <p><u>Mail Order:</u>            Generic: \$10.00            Preferred Brand: \$20.00            Non-Preferred Brand: \$40.00</p> <p>NOTE: If you choose a Preferred or Non-Preferred Brand Drug when a Generic Drug is available, even when your doctor indicates "Dispense as Written" on your prescription, you will have to pay the difference. See the section, <i>Prescription Drug Benefits</i>, to learn how to calculate your payment.</p>
	Medicare covers 80% of the reasonable charges for immunosuppressive drugs during the first year following a covered transplant (after the Medicare Part B deductible).	This program also pays the 20% coinsurance for immunosuppressive drugs during the first year following a covered transplant.	You pay nothing for immunosuppressive drugs during the first year following a covered transplant.

Private Duty Nursing

No coverage under Medicare.

This plan covers the services of a Registered Professional Nurse (RN) for care provided in an acute care facility at 80% of BCBSD's allowable charge, up to a maximum of 240 hours during any 12-month period. If an RN is not available, at our discretion, benefits may be provided for the services of a Licensed Practice Nurse (LPN).

You pay 20% of the allowable charges. You also pay any charges incurred after the 240-hour maximum has been met.

## HUMAN ORGAN TRANSPLANT BENEFIT

<b>Benefit:</b>	<b>Medicare Covers:</b>	<b>Special Medicfill Covers:</b>	<b>You Pay:</b>
Human solid organ and tissue transplants	When Medicare pays for an Organ Transplant, benefits are provided on the same basis and at the same level as Inpatient Hospital Benefits, Outpatient Hospital Benefits, and Physician Services, subject to the Medicare Part A and Part B deductibles and coinsurance.	When Medicare pays for an Organ Transplant, this plan provides benefits on the same basis and at the same level as other Special Medicfill benefits.	You pay any charges not covered by Medicare or Special Medicfill, and any charges over the maximum limits of this plan.

## **HOSPITAL AND OTHER FACILITY BENEFITS**

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### **INPATIENT HOSPITAL SERVICES**

Benefits are provided for covered expenses for inpatient hospital care for each benefit period as follows:

- For days 1 through 60, we will pay the Medicare Part A deductible.
- For days 61 through 90, we will pay the specified daily coinsurance.
- For days 91 through 120, we will pay for hospital services for all admissions except for treatment of mental and nervous disorders. You may use these days before you use your 60 Medicare lifetime reserve days. If you use your Medicare lifetime reserve days, we will pay the coinsurance amount.
- For days 121 through 365, we will pay for hospital services except for treatment of mental and nervous disorders.

Covered services include:

- Semi-private room and board and ancillary services. If a private room is medically necessary, benefits are provided at the private room rate.
- Medicare limits coverage to 190 days for admissions for treatment of mental and nervous disorders. We will pay the Part A deductible and specified daily coinsurance for days approved by Medicare.
- When you are admitted to the hospital for dental surgical services approved by Medicare, we will pay the Medicare Part A deductible and the daily coinsurance amount. Dental services are limited to surgery related to the jaw or reduction of any fracture of the jaw or facial bone.

### **SKILLED NURSING FACILITY**

When you are admitted to a Skilled Nursing Facility for a stay approved by Medicare, we will pay the applicable daily coinsurance for days 21 through 100.

### **SERVICES IN HOSPITALS OUTSIDE THE UNITED STATES**

The Medicare program places certain restrictions on payments for admissions outside the United States. If Medicare approves payment for the admission, we will pay the Part A deductible and the daily coinsurance for the first 90 days. We will then pay 100% of the allowable charges for days 91-120.

If the admission does not qualify for payment under Medicare, but if it meets Medicare criteria for an inpatient admission within the United States and we approve the admission, we will pay for covered services as defined by Medicare law at 100% of the allowable charge for 120 days of inpatient care.

## **OUTPATIENT HOSPITAL SERVICES**

We pay the Medicare Part B deductible and then we pay 20% of the reasonable charge for covered services for care in the outpatient department of the hospital. If care is rendered in a free-standing facility and Medicare pays, then we will pay the deductible, if any, and the coinsurance amount.

Covered services include:

- **Emergency Treatment** which is treatment for accidental injury or for sudden and serious medical conditions. These services must be rendered within 72 hours after the accident or onset of the emergency condition.
- **Minor Surgery.**
- **Radiation Therapy and Chemotherapy** for proven malignancies and neoplastic diseases.
- **Diagnostic imaging services, laboratory and machine testing.**
- **Physical Therapy** (subject to Medicare criteria).
- **Anesthesia.**
- **Hemodialysis.**
- **Clinical Services.**
- **Injections** (not including routine immunizations except for influenza, pneumococcal and hepatitis B vaccines which are fully covered by Medicare).
- **Coverage Outside the United States** - In those cases where Medicare will pay, we will pay the deductible and coinsurance amounts. In those cases where Medicare does not pay, we will pay for those covered services as defined by Medicare at 100% of the allowable charge.

## **SURGICAL-MEDICAL BENEFITS**

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We pay the Medicare Part B deductible, and then we pay 20% of the Medicare reasonable charge for covered professional services provided or ordered by a physician.

### **COVERED SERVICES**

Covered services are as defined by Medicare and include:

- Appliances and Durable Medical Equipment.
- Ambulance Services.
- Home and Office Visits (excluding routine physical examinations).
- Inpatient Hospital Medical Visits.
- Surgery.
- Imaging Services.
- Physical Therapy (subject to Medicare criteria).
- Occupational and Speech Therapy.
- Anesthesia.
- Inpatient Consultations.
- Inpatient Skilled Nursing Facility medical visits.
- Medical Emergency Care in the outpatient department of a hospital or other facility approved by us.
- Radiation Therapy and Chemotherapy for proven malignancies and neoplastic diseases.
- Laboratory and machine testing.
- Injections (not including routine immunizations).
- Clinic Visits.
- Chiropractic Services limited to manual manipulation of the spine to correct a subluxation (a condition where one or more of the bones of your spine move out of position) that can be demonstrated by X-ray.

### **OUTPATIENT TREATMENT FOR MENTAL AND NERVOUS DISORDERS**

We will pay the Medicare Part B deductible and then 50% of the reasonable charge for outpatient treatment of mental and nervous disorders. If you receive outpatient care in a partial hospitalization program or in the outpatient department of a hospital, we will pay 20% of the reasonable charge.

**SERVICES OUTSIDE THE UNITED STATES**

- For services outside of the United States, in those cases where Medicare will pay, we will pay the Part B deductible and coinsurance amounts.
- In those cases where Medicare will not pay, benefits for services outside the United States are provided at 20% of BCBSD's allowable charge.

## **CANCER SCREENING BENEFITS**

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Medicare pays for certain cancer screening tests. Some tests are covered at 100% with no Part B deductible requirement (these tests are not listed below; check the *Medicare and You* manual for more information). When Medicare covers cancer screening tests, we pay 20% of the Medicare reasonable charge and/or the Part B deductible for covered professional services provided or ordered by a physician.

### **ANNUAL ROUTINE MAMMOGRAM**

We will pay 20% of Medicare Eligible expenses, with no Part B deductible requirement, for an annual routine mammogram for females age 40 and over.

### **ROUTINE PELVIC EXAM AND PAP SMEAR**

When a routine Pap smear for cancer screening is not covered by Medicare, we will pay 100% of our allowable charge for one routine Pap smear every 12 months.

When pelvic exams for cancer screening are covered by Medicare, this plan covers 20% of Medicare Eligible expenses.

### **COLORECTAL CANCER SCREENING**

When colorectal cancer screening tests are covered by Medicare, we will pay 20% of the Medicare Eligible expense. Tests include colonoscopy, flexible sigmoidoscopy, and barium enema. See the Preventive Benefits Highlights, above, for more information..

## **OTHER COVERED BENEFITS**

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The following benefits are provided in addition to those in the Hospital and Surgical-Medical Benefits section of this booklet. Covered services include:

### **PRIVATE DUTY NURSING - INPATIENT**

When you are an inpatient in an acute hospital ('hospital' is defined in the Definitions section of this booklet), benefits are provided for the medically necessary services of a Registered Professional Nurse (R.N.) at 80% of BCBSD's allowable charge, up to a maximum of 240 hours during a 12-month period.

This benefit is provided only when all of the following conditions are met:

- The nursing service is available;
- The service is prescribed by the attending doctor;
- The service is connected with the condition for which hospital care and treatment are being rendered;
- The service is medically necessary; and
- The service is approved by the hospital.

Private duty nursing is not covered when it is provided as a convenience for you, whether or not prescribed by your doctor, or when it is provided at your request or your family's request.

If an R.N. is not available, then at our discretion, benefits may be provided for a Licensed Practical Nurse (L.P.N.) at 80% of BCBSD's allowable charge.

## **PRESCRIPTION DRUG BENEFITS**

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BCBSD works with Argus Health Systems, Inc. (Argus) to offer your drug benefits. If you have questions about your drug benefits, call Argus at 1-800-314-9674. Certain prescription drugs may require BCBSD's approval prior to dispensing.

### **COPAYMENTS**

Prescription drugs are subject to the following copayments per prescription or refill:

- Generic: \$10.00
- Preferred Brand: \$20.00
- Non-Preferred Brand: \$40.00

NOTE: If you choose a Preferred or Non-Preferred Brand Drug when a Generic Drug is available, even when your doctor indicates "Dispense as Written" on your prescription, you will have to pay the difference. To calculate the difference, take

- the charge for the Preferred or Non-Preferred Brand Drug,
- less the charge for the Generic Drug,
- plus the copayment and/or coinsurance for the Generic Drug
- which equals the amount you have to pay.

### **BENEFITS**

The following are covered when prescribed for use outside the hospital:

- caution legend drugs (these require a prescription according to Federal and State laws)
- compounded prescriptions with at least one caution legend drug
- injectible insulin prescribed by your doctor
- contraceptive devices prescribed by your doctor and FDA approved
- needles and syringes under 5 ccs\* prescribed by your doctor

\*Syringes over 5ccs are covered under your Durable Medical Equipment benefit.

### **DISPENSING LIMITS**

- 34-day supply through a retail pharmacy
- 90-day supply through mail order
- limit of a 3-month supply for oral contraceptives at one time
- limit of one supply per lifetime of smoking cessation drugs (supply limited to one consecutive 3-month period; the 3-month period is counted from the date dispensed)
- renewals past one year from the original prescription are not accepted.

NOTE: BCBSD may apply other dispensing limits.

**HOW THE RETAIL PROGRAM WORKS**

**PHARMACIES IN THE NETWORK**

To fill or refill prescriptions, show your Drug Card at the pharmacy. You'll be asked to pay only the copayment or coinsurance. There's a separate copayment and/or coinsurance for each prescription. The drug store handles all other billing for you.

**PHARMACIES NOT IN THE NETWORK**

You must pay the pharmacy the full charge. You may then complete the *Argus Direct Reimbursement Claim Form* and send it to Argus. To receive a form, call Argus at 1-800-314-9674. Argus pays you the allowable charge less the copayment or coinsurance. Because the allowable charge may be less than the actual charge, you may pay more than the copayment and/or coinsurance when you use a pharmacy not in the Argus network.

To learn about pharmacies in the Argus network, call Argus at 1-800-314-9674.

**WHAT'S NOT COVERED UNDER THE DRUG PROGRAM**

In addition to the exclusions listed in the section, *Exclusions*, there is no coverage for:

- drugs other than caution legend drugs and injectible insulin
- devices, other than
  - those related to diabetic care, and
  - FDA-approved contraceptives
- administration or injection of drugs
- vitamins, except those that by law need a prescription
- drugs you get while a patient in a health care facility
- drugs provided under Workers Compensation laws
- drugs covered through any government agency, unless required by law
- drugs for weight loss

## **HUMAN ORGAN TRANSPLANT BENEFIT**

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The benefits listed in this section are only available for services related to medically necessary human organ transplants. Benefits for human organ transplants are available only when Medicare pays for an organ transplant.

### **Benefits Available**

Subject to all the terms and conditions of this benefit plan, when a human organ transplant is medically necessary, the following benefits are available for that transplant:

- If Medicare covers these services, covered Hospital and Surgical-Medical services as specified under this benefit plan. Benefits are payable on the same basis and at the same level as other similar benefits under this benefit plan.
- If Medicare covers these services, surgical, storage and transportation costs incurred and directly related to the donation of a human organ used in a covered transplant procedure.
- If Medicare covers these services, transportation to and from the site of the covered transplant procedure is covered for the transplant recipient and one other person. If the recipient is a minor, transportation costs for two other persons accompanying the recipient are covered.

### **Benefit Limitations**

- Benefits under this section are payable only for those services that Medicare will pay, with the exception of those non-Medicare covered services specified in the *Other Covered Benefits* section of this booklet.
- All other terms, conditions, limitations and exclusions of your health benefits plan apply to the provision of this benefit, including applicable waiting periods, deductibles, coinsurance and coverage termination provisions.

## **EXCLUSIONS**

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The following services and other items are excluded from your coverage under this Medicfill plan:

- Acupuncture.
- All procedures for refractive correction.
- Any service necessitated by an act of war declared or undeclared which occurs after the effective date of this plan, or by service in the armed forces of any country, or by any criminal act in which you conspired or took part.
- Any service or benefit provided or available, to any extent, to you under federal, state or local Workers' Compensation laws, occupational disease laws or other laws concerning job related injuries or conditions.
- Any service or supply specified as an exclusion under the Medicare program or denied by Medicare except any service or supply expressly covered as a benefit by this plan.
- Blood or blood donor services, including blood components.
- Chiropractic services, except those to correct a subluxation of the spine.
- Computerized gait analysis or electrodiagnostic testing.
- Dental X-rays and appliances and the services of a dentist, except Medicare covered surgery involving the bone of the jaw or facial bone.
- Eyeglasses, contact lenses, the examination, prescription or fitting of same, and all procedures for refractive correction.
- Hearing aids and the examination, prescription or fitting of same.
- Immunizations, unless specified elsewhere in this booklet.
- Long-term care.
- Orthotics, including all equipment, devices, foot inserts, arch supports, lifts and corrective shoes.
- Rest cures, custodial care or homelike care, whether or not recommended by your doctor.
- Routine foot care.
- Services and supplies covered by Medicare Part A and Part B benefits, except those items and services expressly provided in this plan.
- Services and supplies for or related to visual therapy or orthoptics.
- Services and supplies which are experimental or investigational in nature meaning any treatment, procedure, facility, equipment, drugs, drug usage, devices or supplies not recognized as accepted medical practice and any of such items requiring federal or other government agency approval not granted at the time services were rendered.
- Services by a medical department maintained by your employer.



## Paid Claims Report

Account Name: Kent County Levy Court

Account #: 777154

(Paid From January 2009 Thru December 2009)

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<u>Line</u>	<u>Amount Paid</u>
IPA Facility	\$475,321.79
PPO Facility	\$1,167,430.58
Traditional Facility	\$52,109.65
IPA Pharmacy	\$128,966.14
PPO Pharmacy	\$271,920.80
Traditional Pharmacy	\$141,554.12
IPA Professional	\$280,664.18
PPO Professional	\$589,310.18
Traditional Professional	\$61,319.69
<b>Total Amount Paid:</b>	<b>\$3,166,597.13</b>



# High Claimant Report

Account Name: Kent County Levy Court

Account #: 777154

(Paid From January 2009 Thru December 2009)

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<u>Member Relation</u>	<u>Amount Paid</u>
Spouse	\$26,578.79
Spouse	\$29,584.72
Spouse	\$68,126.31
Spouse	\$95,802.96
Spouse	\$122,488.96
Spouse	\$147,900.27
Subscriber	\$21,016.72
Subscriber	\$22,215.43
Subscriber	\$22,339.03
Subscriber	\$23,011.57
Subscriber	\$23,773.70
Subscriber	\$25,300.30
Subscriber	\$26,336.19
Subscriber	\$28,052.34
Subscriber	\$31,889.51
Subscriber	\$32,442.06
Subscriber	\$32,532.48
Subscriber	\$38,476.99



# High Claimant Report

Account Name: Kent County Levy Court

Account #: 777154

(Paid From January 2009 Thru December 2009)

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<u>Member Relation</u>	<u>Amount Paid</u>
Subscriber	\$39,547.15
Subscriber	\$43,363.75
Subscriber	\$53,206.51
Subscriber	\$54,842.90
Subscriber	\$64,163.81
Subscriber	\$67,170.55
Subscriber	\$70,685.35
Subscriber	\$76,584.96
Subscriber	\$157,037.68
Subscriber	\$160,433.09
<b>Total Amount Paid:</b>	<b>\$1,604,884.08</b>



# Claims Stratification Report

Account Name: Kent County Levy Court

Account #: 777154

(Paid From January 2009 Thru December 2009)

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<u>Dollar Range Desc</u>	<u>Number of Claimants</u>	<u>Percent Total Claimant</u>	<u>Amount Paid</u>	<u>Percent Amount Paid</u>
Less Than \$500	109	20.72%	\$9,634.53	0.30%
\$500-\$999	71	13.50%	\$51,322.65	1.62%
\$1,000-\$1,499	54	10.27%	\$66,651.81	2.10%
\$1,500 - \$1,999	39	7.41%	\$69,113.38	2.18%
\$2,000 - \$2,499	22	4.18%	\$49,189.10	1.55%
\$2,500 - \$2,999	21	3.99%	\$57,603.72	1.82%
\$3,000 - \$3,499	21	3.99%	\$68,897.34	2.17%
\$3,500 - \$3,999	22	4.18%	\$82,090.15	2.59%
\$4,000 - \$4,499	15	2.85%	\$83,714.11	2.01%
\$4,500 - \$4,999	14	2.66%	\$68,442.27	2.10%
\$5,000 - \$9,999	78	14.83%	\$533,521.10	18.84%
\$10,000 - \$14,999	22	4.18%	\$275,003.71	8.68%
\$15,000 - \$19,999	10	1.90%	\$170,729.18	5.39%
\$20,000 - \$24,999	5	0.95%	\$112,356.45	3.55%
\$25,000 And Up	23	4.37%	\$1,492,527.63	47.10%
<b>Total Values:</b>	<b>526</b>	<b>100.00%</b>	<b>\$3,188,597.13</b>	<b>100.00%</b>



# Exposure Summary Report

Account Name: Kent County Levy Court

Account #: 777154

Exposure Period January 2009 - December 2009

<u>Product Desc</u>	<u>Category Desc</u>	<u>Ind Count</u>	<u>Ind SPS Count</u>	<u>Chd Count</u>	<u>Ind Children Count</u>	<u>Family Count</u>	<u>Total Contract Exposure</u>
Traditional	Medicfill	895	0	0	0	0	895
IPA	Regular	835	128	133	83	229	1,408
PPO	Regular	1,540	144	157	107	124	2,072
<b>Total Values:</b>		3,270	272	290	190	353	4,375



## Paid Claims Report

Account Name: Kent County Levy Court

Account #: 777154

(Paid From January 2008 Thru December 2008)

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<u>Line</u>	<u>Amount Paid</u>
IPA Facility	\$393,642.37
PPO Facility	\$788,281.37
Traditional Facility	\$23,756.54
IPA Pharmacy	\$137,749.90
PPO Pharmacy	\$265,073.72
Traditional Pharmacy	\$125,328.21
IPA Professional	\$254,039.35
PPO Professional	\$580,879.78
Traditional Professional	\$48,245.01
<b>Total Amount Paid:</b>	<b>\$2,598,998.23</b>

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# High Claimant Report

Account Name: Kent County Levy Court

Account #: 777154

(Paid From January 2008 Thru December 2008)

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<u>Member Relation</u>	<u>Amount Paid</u>
Child	\$20,175.41
Spouse	\$24,325.17
Spouse	\$28,949.17
Spouse	\$29,609.33
Spouse	\$30,818.70
Spouse	\$45,090.86
Spouse	\$92,748.14
Spouse	\$102,575.35
Subscriber	\$20,586.78
Subscriber	\$21,417.78
Subscriber	\$22,018.18
Subscriber	\$22,505.74
Subscriber	\$22,754.70
Subscriber	\$25,745.11
Subscriber	\$27,481.42
Subscriber	\$28,412.44
Subscriber	\$29,250.10
Subscriber	\$30,143.64



# High Claimant Report

Account Name: Kent County Levy Court

Account #: 777154

(Paid From January 2008 Thru December 2008)

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<u>Member Relation</u>	<u>Amount Paid</u>
Subscriber	\$31,200.67
Subscriber	\$32,408.91
Subscriber	\$33,888.47
Subscriber	\$34,365.91
Subscriber	\$37,628.10
Subscriber	\$39,991.65
Subscriber	\$45,000.07
Subscriber	\$49,794.22
Subscriber	\$80,171.56
Subscriber	\$81,794.38
Subscriber	\$85,966.29
<b>Total Amount Paid:</b>	<b>\$1,184,828.21</b>



# Claims Stratification Report

Account Name: Kent County Levy Court

Account #: 777154

(Paid From January 2008 Thru December 2008)

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<u>Dollar Range Desc</u>	<u>Number of Claimants</u>	<u>Percent Total Claimant</u>	<u>Amount Paid</u>	<u>Percent Amount Paid</u>
Less Than \$500	124	23.68%	\$26,254.91	1.01%
\$500-\$999	58	11.07%	\$40,480.40	1.56%
\$1,000-\$1,499	52	9.92%	\$65,281.48	2.51%
\$1,500 - \$1,999	43	8.21%	\$75,875.57	2.92%
\$2,000 - \$2,499	40	7.63%	\$89,194.89	3.43%
\$2,500 - \$2,999	24	4.58%	\$66,252.52	2.55%
\$3,000 - \$3,499	19	3.63%	\$60,783.21	2.34%
\$3,500 - \$3,999	16	3.05%	\$60,133.71	2.32%
\$4,000 - \$4,499	12	2.29%	\$51,075.45	1.97%
\$4,500 - \$4,999	15	2.86%	\$70,833.51	2.72%
\$5,000 - \$9,999	74	14.12%	\$544,657.75	20.97%
\$10,000 - \$14,999	10	1.91%	\$121,830.04	4.69%
\$15,000 - \$19,999	6	1.53%	\$139,703.56	5.38%
\$20,000 - \$24,999	7	1.34%	\$153,783.74	5.92%
\$25,000 And Up	22	4.20%	\$1,031,045.47	39.70%
<b>Total Values:</b>	<b>524</b>	<b>100.00%</b>	<b>\$2,596,996.23</b>	<b>100.00%</b>



BlueCross BlueShield  
of Delaware

# Exposure Summary Report

Account Name: Kent County Levy Court

Account #: 777154

Exposure Period January 2008 - December 2008

<u>Product Desc</u>	<u>Category Desc</u>	<u>Ind Count</u>	<u>Ind SPS Count</u>	<u>Ind Chd Count</u>	<u>Ind Children Count</u>	<u>Family Count</u>	<u>Total Contract Exposure</u>
Traditional	Medicfill	783	0	0	0	0	783
IPA	Regular	861	115	154	84	196	1,410
PPO	Regular	1,601	120	156	100	130	2,107
<b>Total Values:</b>		3,245	235	310	184	326	4,300



## Paid Claims Report

Account Name: Kent County Levy Court

Account #: 777154

(Paid From January 2007 Thru December 2007)

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<u>Line</u>	<u>Amount Paid</u>
IPA Facility	\$338,665.99
PPO Facility	\$573,456.61
Traditional Facility	\$80,374.88
IPA Pharmacy	\$125,149.01
PPO Pharmacy	\$218,751.29
Traditional Pharmacy	\$102,984.35
IPA Professional	\$227,411.19
PPO Professional	\$408,896.78
Traditional Professional	\$48,983.37
<b>Total Amount Paid:</b>	<b>\$2,104,473.47</b>



BlueCross BlueShield  
of Delaware

## High Claimant Report

Account Name: Kent County Levy Court

Account #: 777154

(Paid From January 2007 Thru December 2007)

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<u>Member Relation</u>	<u>Amount Paid</u>
Spouse	\$38,322.65
Spouse	\$39,679.72
Spouse	\$44,538.02
Spouse	\$55,992.54
Spouse	\$86,251.75
Subscriber	\$20,026.38
Subscriber	\$21,616.80
Subscriber	\$22,350.52
Subscriber	\$23,513.56
Subscriber	\$28,713.38
Subscriber	\$39,103.68
Subscriber	\$40,735.86
Subscriber	\$41,420.45
Subscriber	\$51,016.88
Subscriber	\$70,515.50
Subscriber	\$86,374.84
<b>Total Amount Paid:</b>	<b>\$710,172.53</b>



# Claims Stratification Report

Account Name: Kent County Levy Court

Account #: 777154

(Paid From January 2007 Thru December 2007)

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<u>Dollar Range Desc</u>	<u>Number of Claimants</u>	<u>Percent Total Claimant</u>	<u>Amount Paid</u>	<u>Percent Amount Paid</u>
Less Than \$500	138	28.54%	\$31,138.02	1.48%
\$500-\$999	72	13.85%	\$51,078.30	2.43%
\$1,000-\$1,499	49	9.42%	\$60,512.86	2.88%
\$1,500 - \$1,999	35	6.73%	\$59,528.41	2.63%
\$2,000 - \$2,499	37	7.12%	\$82,557.94	3.92%
\$2,500 - \$2,999	33	6.35%	\$89,481.72	4.25%
\$3,000 - \$3,499	18	3.46%	\$58,961.32	2.80%
\$3,500 - \$3,999	11	2.12%	\$40,200.40	1.91%
\$4,000 - \$4,499	6	1.54%	\$34,136.64	1.62%
\$4,500 - \$4,999	9	1.73%	\$43,108.41	2.05%
\$5,000 - \$9,999	66	12.69%	\$470,784.69	22.37%
\$10,000 - \$14,999	21	4.04%	\$254,705.37	12.10%
\$15,000 - \$19,999	7	1.35%	\$118,106.86	5.81%
\$20,000 - \$24,999	4	0.77%	\$87,507.26	4.16%
\$25,000 And Up	12	2.31%	\$622,665.27	29.59%
<b>Total Values:</b>	<b>520</b>	<b>100.00%</b>	<b>\$2,104,473.47</b>	<b>100.00%</b>



# Exposure Summary Report

Account Name: Kent County Lewy Court

Account #: 777154

Exposure Period January 2007 - December 2007

<u>Product Desc</u>	<u>Category Desc</u>	<u>Ind Count</u>	<u>Ind SPS Count</u>	<u>Chd Count</u>	<u>Ind Children Count</u>	<u>Family Count</u>	<u>Total Contract Exposure</u>
Traditional	Medicfill	721	0	0	0	0	721
IPA	Regular	902	131	139	86	207	1,465
PPO	Regular	1,472	160	120	92	86	1,930
<b>Total Values:</b>		3,095	291	259	178	293	4,116

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Employee Name	Position	Option	Coverage	DOB	Sex	Zip	Hire Date	Premium	Co. Share	Dep. Cont.	Emp. Share
		HMO-Hi	Family	12/18/60	M	19938	06/08/92	\$1,720.07	\$669.32	\$630.45	\$420.30
		PPO	Family	09/25/76	M	19934	03/14/08	\$1,874.10	\$669.32	\$722.87	\$481.91
		PPO	Employee	06/25/75	M	19078	01/14/08	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	05/21/88	M	19934	08/01/09	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Spouse	1/17/1953	M	19901	1/4/2005	\$1,539.43	\$669.32	\$522.07	\$348.04
		PPO	Employee	1/7/1948	M	19952	6/5/2006	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	12/21/92	M	19964	10/31/2005	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Spouse	06/15/35	M	19977	01/02/97	\$1,539.43	\$669.32	\$522.07	\$348.04
		PPO	Employee	08/23/55	F	19964	08/28/00	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Child	08/09/71	F	19901	10/01/07	\$1,070.91	\$669.32	\$240.95	\$160.64
		PPO	Employee	09/03/48	M	19952	02/25/07	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	01/18/80	M	19904	07/12/04	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	09/10/54	M	19963	07/15/02	\$669.32	\$669.32	\$0.00	\$0.00
		HMO-Hi	Family	12/04/53	M	19904	10/26/87	\$1,720.07	\$669.32	\$630.45	\$420.30
		PPO	Family	04/16/64	M	19943	10/07/91	\$1,874.10	\$669.32	\$722.87	\$481.91
		HMO-Hi	Employee	09/11/56	M	19952	06/01/98	\$614.31	\$614.31	\$0.00	\$0.00
		HMO-Hi	Employee	03/24/56	M	19963	09/28/98	\$614.31	\$614.31	\$0.00	\$0.00
		PPO	Employee	10/21/50	M	19968	07/24/08	\$669.32	\$669.32	\$0.00	\$0.00
		HMO-Hi	Employee	08/04/82	M	19701	09/28/06	\$614.31	\$614.31	\$0.00	\$0.00
		HMO-Hi	Employee	11/16/74	M	19961	11/15/93	\$614.31	\$614.31	\$0.00	\$0.00
		PPO	Child	09/10/66	F	19934	12/29/86	\$1,070.91	\$669.32	\$240.95	\$160.64
		HMO-Hi	Employee	10/7/1954	M	19952	11/28/2005	\$614.31	\$614.31	\$0.00	\$0.00
		PPO	Employee	03/07/52	M	19952	03/06/90	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	01/11/65	F	19962	01/08/07	\$669.32	\$669.32	\$0.00	\$0.00
		HMO-Hi	Spouse	01/18/51	F	19953	12/04/00	\$1,412.91	\$669.32	\$446.15	\$297.44
		HMO-Hi	Employee	09/24/80	M	19904	12/05/00	\$614.31	\$614.31	\$0.00	\$0.00
		HMO-Hi	Employee	07/17/61	F	19953	11/17/03	\$614.31	\$614.31	\$0.00	\$0.00
		HMO-Hi	Employee	01/18/64	F	19977	01/13/00	\$614.31	\$614.31	\$0.00	\$0.00
		PPO	Employee	03/20/64	M	19938	12/03/90	\$669.32	\$669.32	\$0.00	\$0.00
		HMO-Hi	Employee	08/19/68	M	21620	10/26/92	\$614.31	\$614.31	\$0.00	\$0.00
		PPO	Child	02/20/79	M	19938	10/22/06	\$1,070.91	\$669.32	\$240.95	\$160.64
		PPO	Employee	01/18/57	F	19962	01/29/90	\$669.32	\$669.32	\$0.00	\$0.00
		HMO-Hi	Employee	07/03/77	M	19960	5/6/2002	\$614.31	\$614.31	\$0.00	\$0.00
		HMO-Hi	Spouse	10/07/66	M	19960	8/27/2007	\$1,412.91	\$669.32	\$446.15	\$297.44
		PPO	Employee	07/11/62	F	19943	07/21/03	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	04/09/58	F	19943	12/06/04	\$669.32	\$669.32	\$0.00	\$0.00
		HMO-Hi	Employee	10/31/56	M	19963	08/13/84	\$614.31	\$614.31	\$0.00	\$0.00
		HMO-Hi	Employee	02/11/66	M	19962	11/10/97	\$614.31	\$614.31	\$0.00	\$0.00
		HMO-Hi	Spouse	03/29/76	M	19943	1/18/2002	\$1,412.91	\$669.32	\$446.15	\$297.44
		HMO-Hi	Employee	09/11/60	F	19943	12/10/03	\$614.31	\$614.31	\$0.00	\$0.00
		HMO-Hi	Spouse	03/19/51	M	19934	11/16/98	\$1,412.91	\$669.32	\$446.15	\$297.44
		PPO	Employee	10/26/69	M	19904	11/17/95	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	04/18/74	M	19952	11/20/07	\$669.32	\$669.32	\$0.00	\$0.00
		HMO-Hi	Family	10/04/61	M	19962	01/15/06	\$1,720.07	\$669.32	\$630.45	\$420.30
		HMO-Hi	Employee	06/30/77	F	19934	09/18/06	\$614.31	\$614.31	\$0.00	\$0.00
		HMO-Hi	Employee	06/11/65	F	19977	07/21/03	\$1,412.91	\$669.32	\$446.15	\$297.44
		HMO-Hi	Child	05/21/74	F	19943	08/20/07	\$982.90	\$669.32	\$188.15	\$125.43
		PPO	Employee	10/28/62	F	19904	02/18/08	\$669.32	\$669.32	\$0.00	\$0.00

Employee Name	Position	Option	Coverage	DOB	Sex	Zip	Hire Date	Premium	Co. Share	Dep. Cont.	Emp. Share
		PPO	Employee	02/12/53	F	19977	03/25/91	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Family	10/03/61	M	19904	01/03/07	\$1,874.10	\$669.32	\$722.87	\$481.91
		PPO	Family	01/09/66	M	19904	06/14/99	\$1,874.10	\$669.32	\$722.87	\$481.91
		PPO	Child	04/04/70	F	19943	10/01/07	\$1,070.91	\$669.32	\$240.95	\$160.64
		PPO	Employee	08/13/57	F	19904	09/14/92	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	8/27/1969	F	19950	6/1/2005	\$669.32	\$669.32	\$0.00	\$0.00
		HMO-Hi	Child	04/01/67	F	19968	01/12/98	\$982.90	\$669.32	\$188.15	\$125.43
		HMO-Hi	Employee	07/29/49	F	19952	11/13/00	\$614.31	\$614.31	\$0.00	\$0.00
		PPO	Child	1/18/1979	F	21620	6/1/2005	\$1,070.91	\$669.32	\$240.95	\$160.64
		HMO-Lo	Family	10/2/1966	M	19952	8/30/2009	\$1,590.76	\$669.32	\$552.86	\$368.58
		PPO	Employee	05/19/56	F	19961	09/10/07	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Child	01/10/64	M	19952	7/3/2006	\$1,070.91	\$669.32	\$240.95	\$160.64
		HMO-Hi	Employee	3/10/1933	F	19901	6/30/2008	\$614.31	\$614.31	\$0.00	\$0.00
		PPO	Employee	12/21/52	F	19904	09/05/06	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Spouse	09/25/57	F	19904	08/01/90	\$1,539.43	\$669.32	\$522.07	\$348.04
		PPO	Employee	08/22/67	F	19904	11/02/98	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	06/18/54	F	19952	10/05/92	\$669.32	\$669.32	\$0.00	\$0.00
		HMO-Hi	Employee	2/5/1961	F	19963	4/10/2006	\$614.31	\$614.31	\$0.00	\$0.00
		HMO-Hi	Spouse	09/25/71	F	19904	10/15/2001	\$1,412.91	\$669.32	\$446.15	\$297.44
		PPO	Family	06/24/62	F	19934	06/12/06	\$1,874.10	\$669.32	\$722.87	\$481.91
		PPO	Child	07/25/68	F	19953	09/30/91	\$1,070.91	\$669.32	\$240.95	\$160.64
		PPO	Employee	07/15/61	M	19953	08/22/94	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	03/09/51	F	19963	9/10/2002	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	03/11/54	M	19901	10/15/90	\$669.32	\$669.32	\$0.00	\$0.00
		HMO-Hi	Child	01/22/69	M	19968	07/06/93	\$982.90	\$669.32	\$188.15	\$125.43
		HMO-Hi	Child	03/30/57	M	19946	06/02/99	\$982.90	\$669.32	\$188.15	\$125.43
		HMO-Hi	Employee	07/19/71	M	19977	10/20/97	\$614.31	\$614.31	\$0.00	\$0.00
		PPO	Employee	08/03/61	M	19901	03/08/04	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	04/11/64	M	19946	06/08/92	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Spouse	10/16/55	F	19952	01/15/09	\$1,539.43	\$669.32	\$522.07	\$348.04
		PPO	Employee	04/07/58	F	19946	10/08/82	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	03/01/60	F	19938	12/06/93	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	12/29/54	F	19901	10/01/07	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Spouse	01/26/53	M	19901	01/03/95	\$1,539.43	\$669.32	\$522.07	\$348.04
		HMO-Hi	Family	11/07/67	F	19901	04/05/99	\$1,720.07	\$669.32	\$630.45	\$420.30
		PPO	Employee	10/13/1983	M	19966	5/16/2009	\$669.32	\$669.32	\$0.00	\$0.00
		HMO-Hi	Child	3/3/1984	F	19966	7/14/2008	\$982.90	\$669.32	\$188.15	\$125.43
		PPO	Child	4/10/1969	M	19943	8/27/1998	\$1,070.91	\$669.32	\$240.95	\$160.64
		PPO	Employee	01/27/52	M	19952	10/07/91	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	09/10/82	M	19963	03/12/07	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	1/2/1961	F	19901	5/2/2005	\$669.32	\$669.32	\$0.00	\$0.00
		HMO-Hi	Employee	01/04/59	M	19956	10/15/2002	\$614.31	\$614.31	\$0.00	\$0.00
		PPO	Employee	05/01/66	F	19960	3/5/2001	\$669.32	\$669.32	\$0.00	\$0.00
		HMO-Hi	Employee	09/29/47	F	19904	1/5/2004	\$614.31	\$614.31	\$0.00	\$0.00
		HMO-Hi	Employee	08/11/62	M	19946	2/13/1997	\$614.31	\$614.31	\$0.00	\$0.00
		HMO-Hi	Child	05/12/62	M	19950	2/12/2007	\$982.90	\$669.32	\$188.15	\$125.43
		HMO-Hi	Family	8/7/1967	M	19963	8/1/2005	\$1,720.07	\$669.32	\$630.45	\$420.30
		PPO	Employee	04/30/68	M	19963	10/1/794	\$669.32	\$669.32	\$0.00	\$0.00

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Employee Name	Position	Option	Coverage	DOB	Sex	Zip	Hire Date	Premium	Co. Share	Dep. Cont.	Emp. Share
		PPO	Employee	8/24/1984	F	19901	10/3/2005	\$669.32	\$669.32	\$0.00	\$0.00
		HMO-Hi	Spouse	09/29/47	F	19954	10/26/92	\$1,412.91	\$669.32	\$446.15	\$297.44
		HMO-Hi	Employee	09/08/74	F	19963	5/1/2002	\$614.31	\$614.31	\$0.00	\$0.00
		PPO	Employee	04/15/74	F	19904	05/20/07	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	2/11/1971	M	19977	3/18/2005	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Family	10/15/1960	M	19702	4/30/2007	\$1,874.10	\$669.32	\$722.87	\$481.91
		HMO-Hi	Employee	4/20/1971	M	19904	12/15/2008	\$614.31	\$614.31	\$0.00	\$0.00
		PPO	Employee	01/3/178	M	19901	06/12/00	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Spouse	04/11/47	M	19962	10/21/91	\$1,539.43	\$669.32	\$522.07	\$348.04
		PPO	Spouse	09/15/60	M	19901	07/22/96	\$1,539.43	\$669.32	\$522.07	\$348.04
		HMO-Hi	Employee	08/04/54	F	19938	1/3/2003	\$614.31	\$614.31	\$0.00	\$0.00
		PPO	Child	06/03/81	F	19977	12/2/2002	\$1,070.91	\$669.32	\$240.95	\$160.64
		HMO-Hi	Family	11/05/58	M	19943	4/29/2007	\$1,720.07	\$669.32	\$630.45	\$420.30
		PPO	Employee	09/07/64	F	19904	07/17/89	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	12/22/85	M	19901	07/09/07	\$669.32	\$669.32	\$0.00	\$0.00
		HMO-Hi	Spouse	02/24/59	M	19901	7/18/2006	\$1,412.91	\$669.32	\$446.15	\$297.44
		PPO	Employee	04/03/52	F	19977	05/20/94	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Spouse	7/23/1966	F	19962	3/23/2005	\$1,539.43	\$669.32	\$522.07	\$348.04
		PPO	Employee	02/08/52	F	19901	10/06/93	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Family	05/05/66	M	19934	10/15/90	\$1,874.10	\$669.32	\$722.87	\$481.91
		PPO	Employee	04/01/56	F	19901	06/01/04	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	08/21/58	F	19943	01/13/00	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Child	03/30/79	M	19901	07/19/09	\$1,070.91	\$669.32	\$240.95	\$160.64
		PPO	Employee	07/25/46	M	19962	10/18/99	\$669.32	\$669.32	\$0.00	\$0.00
		HMO-Hi	Employee	01/06/38	F	19901	1/7/2003	\$614.31	\$614.31	\$0.00	\$0.00
		HMO-Hi	Employee	04/28/73	M	19952	02/15/94	\$614.31	\$614.31	\$0.00	\$0.00
		HMO-Hi	Employee	08/10/56	F	19904	06/15/98	\$614.31	\$614.31	\$0.00	\$0.00
		HMO-Hi	Family	12/29/67	M	19958	10/14/2003	\$1,720.07	\$669.32	\$630.45	\$420.30
		HMO-Hi	Family	01/27/55	M	19963	4/1/2002	\$1,720.07	\$669.32	\$630.45	\$420.30
		HMO-Hi	Employee	03/06/66	M	19934	12/20/2006	\$614.31	\$614.31	\$0.00	\$0.00
		PPO	Employee	05/03/87	M	19977	09/29/08	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Spouse	02/14/50	F	19934	07/23/07	\$1,539.43	\$669.32	\$522.07	\$348.04
		PPO	Employee	11/28/56	M	19963	10/09/85	\$669.32	\$669.32	\$0.00	\$0.00
		HMO-Hi	Employee	04/14/80	M	19707	09/10/08	\$614.31	\$614.31	\$0.00	\$0.00
		HMO-Hi	Child	10/28/1965	F	19946	6/29/2005	\$982.90	\$669.32	\$188.15	\$125.43
		HMO-Hi	Employee	12/22/86	F	19904	04/09/07	\$614.31	\$614.31	\$0.00	\$0.00
		HMO-Hi	Family	04/03/76	M	19901	12/2/2002	\$1,720.07	\$669.32	\$630.45	\$420.30
		HMO-Hi	Child	03/15/65	F	19963	3/15/1996	\$982.90	\$669.32	\$188.15	\$125.43
		PPO	Employee	11/14/56	M	19963	01/03/84	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	02/04/75	F	19952	1/22/2008	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Child	03/23/62	F	19943	05/29/97	\$1,070.91	\$669.32	\$240.95	\$160.64
		PPO	Employee	03/15/72	M	19952	09/11/96	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	10/10/55	F	19963	11/08/00	\$669.32	\$669.32	\$0.00	\$0.00
		HMO-Hi	Employee	01/30/43	F	19979	06/18/04	\$614.31	\$614.31	\$0.00	\$0.00
		HMO-Hi	Employee	01/07/75	M	19934	7/9/2001	\$614.31	\$614.31	\$0.00	\$0.00
		PPO	Employee	11/12/78	F	19963	11/19/2001	\$669.32	\$669.32	\$0.00	\$0.00
		HMO-Hi	Employee	04/27/81	M	19946	1/14/2008	\$614.31	\$614.31	\$0.00	\$0.00
		PPO	Child	04/29/56	M	19962	05/08/86	\$1,070.91	\$669.32	\$240.95	\$160.64

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Employee Name	Position	Option	Coverage	DOB	Sex	Zip	Hire Date	Premium	Co. Share	Dep. Cont.	Emp. Share
		PPO	Employee	01/25/73	M	19977	7/2/2001	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	10/04/58	M	19977	01/30/00	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Child	6/10/1966	M	19943	4/4/2005	\$1,070.91	\$669.32	\$240.95	\$160.64
		HMO-Hi	Family	10/12/49	M	19963	5/6/2002	\$1,720.07	\$669.32	\$630.45	\$420.30
		HMO-Hi	Employee	04/03/85	M	19953	7/1/2007	\$614.31	\$614.31	\$0.00	\$0.00
		HMO-Hi	Child	08/26/65	M	19943	10/23/89	\$982.90	\$669.32	\$188.15	\$125.43
		PPO	Employee	06/29/48	M	19934	10/10/00	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Child	10/14/76	F	19950	08/05/96	\$1,070.91	\$669.32	\$240.95	\$160.64
		HMO-Hi	Spouse	02/28/85	M	19962	07/09/07	\$1,412.91	\$669.32	\$446.15	\$297.44
		PPO	Child	09/27/58	F	19904	09/05/85	\$1,070.91	\$669.32	\$240.95	\$160.64
		HMO-Lo	Employee	07/07/61	M	19946	07/1/83	\$568.13	\$568.13	\$0.00	\$0.00
		PPO	Employee	07/16/81	M	19952	01/29/07	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Child	07/31/60	F	19938	3/11/2002	\$1,070.91	\$669.32	\$240.95	\$160.64
		PPO	Spouse	02/20/54	F	19943	03/12/90	\$1,539.43	\$669.32	\$522.07	\$348.04
		PPO	Employee	11/27/84	M	19709	11/01/09	\$669.32	\$669.32	\$0.00	\$0.00
		HMO-Hi	Child	06/27/75	F	19952	8/26/2002	\$982.90	\$669.32	\$188.15	\$125.43
		HMO-Hi	Family	07/28/65	M	19963	7/31/2006	\$1,720.07	\$669.32	\$630.45	\$420.30
		PPO	Employee	01/21/81	F	19977	1/4/2006	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	10/10/63	F	19934	4/2/2001	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	01/28/58	F	19953	10/20/97	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	03/21/59	M	19904	7/6/1999	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	10/16/48	M	19702	08/31/98	\$669.32	\$669.32	\$0.00	\$0.00
		HMO-Hi	Employee	01/30/59	F	19904	05/02/94	\$614.31	\$614.31	\$0.00	\$0.00
		PPO	Spouse	12/7/983	M	19977	7/1/2005	\$1,539.43	\$669.32	\$522.07	\$348.04
		PPO	Employee	03/11/85	M	19901	05/12/08	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	12/13/63	M	19952	10/15/90	\$669.32	\$669.32	\$0.00	\$0.00
		HMO-Hi	Employee	05/28/60	M	19952	06/24/96	\$614.31	\$614.31	\$0.00	\$0.00
		PPO	Employee	08/28/62	M	19901	08/14/89	\$669.32	\$669.32	\$0.00	\$0.00
		HMO-Hi	Employee	05/15/58	M	19952	03/27/06	\$614.31	\$614.31	\$0.00	\$0.00
		PPO	Employee	11/16/83	F	19730	07/02/07	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	09/04/53	M	19953	06/29/09	\$669.32	\$669.32	\$0.00	\$0.00
		HMO-Hi	Employee	07/31/73	M	19904	03/09/09	\$614.31	\$614.31	\$0.00	\$0.00
		HMO-Hi	Employee	04/06/81	F	19904	2/25/2002	\$614.31	\$614.31	\$0.00	\$0.00
		HMO-Hi	Employee	06/22/70	M	19964	01/02/95	\$614.31	\$614.31	\$0.00	\$0.00
		HMO-Hi	Family	02/26/85	F	19952	06/05/06	\$1,720.07	\$669.32	\$630.45	\$420.30
		HMO-Hi	Family	12/28/77	M	19946	02/17/09	\$1,720.07	\$669.32	\$630.45	\$420.30
		PPO	Child	05/15/66	F	19904	09/18/87	\$1,070.91	\$669.32	\$240.95	\$160.64
		PPO	Family	09/03/49	M	19901	11/12/07	\$1,874.10	\$669.32	\$722.87	\$481.91
		PPO	Employee	07/05/74	F	19901	08/14/00	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Child	12/25/70	M	19901	04/28/99	\$1,070.91	\$669.32	\$240.95	\$160.64
		HMO-Lo	Employee	09/16/57	M	19943	10/29/2001	\$568.13	\$568.13	\$0.00	\$0.00
		PPO	Employee	11/13/1954	M	19943	4/25/2005	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	02/09/68	M	19962	7/19/2001	\$669.32	\$669.32	\$0.00	\$0.00
		HMO-Hi	Child	03/25/64	F	19977	11/12/91	\$982.90	\$669.32	\$188.15	\$125.43
		PPO	Employee	10/01/72	M	19904	7/16/2001	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	08/24/72	F	19943	10/04/93	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	07/07/64	F	19934	3/11/2002	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	11/17/74	M	19934	8/13/2001	\$669.32	\$669.32	\$0.00	\$0.00

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Employee Name	Position	Option	Coverage	DOB	Sex	Zip	Hire Date	Premium	Co. Share	Dep. Cont.	Emp. Share
		HMO-Hi	Employee	11/01/67	M	19943	08/05/86	\$614.31	\$614.31	\$0.00	\$0.00
		HMO-Hi	Employee	01/22/69	F	19943	09/02/03	\$614.31	\$614.31	\$0.00	\$0.00
		HMO-Hi	Employee	12/26/58	M	19904	05/06/03	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	04/25/85	F	19904	9/17/2007	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	04/17/57	M	19901	09/03/96	\$669.32	\$669.32	\$0.00	\$0.00
		HMO-Hi	Employee	01/23/79	M	19962	06/24/07	\$614.31	\$614.31	\$0.00	\$0.00
		PPO	Employee	11/25/57	M	19962	10/9/2001	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	05/10/59	F	19938	11/13/84	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	08/17/79	F	19964	12/30/2002	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	07/26/72	F	19934	6/25/2001	\$669.32	\$669.32	\$0.00	\$0.00
		HMO-Hi	Employee	10/31/1982	F	19943	4/4/2005	\$614.31	\$614.31	\$0.00	\$0.00
		PPO	Employee	11/16/71	M	19953	08/02/04	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	08/08/71	M	19901	10/01/07	\$669.32	\$669.32	\$0.00	\$0.00
		HMO-Hi	Family	10/10/60	M	19934	01/06/09	\$1,720.07	\$630.45	\$630.45	\$420.30
		PPO	Child	02/11/63	F	19904	06/20/90	\$1,070.91	\$240.95	\$240.95	\$160.64
		PPO	Spouse	07/23/66	M	19934	01/25/99	\$1,539.43	\$669.32	\$522.07	\$348.04
		HMO-Hi	Child	09/28/49	M	19904	09/28/95	\$982.90	\$669.32	\$188.15	\$125.43
		PPO	Child	02/15/70	F	20169	03/24/75	\$1,070.91	\$669.32	\$240.95	\$160.64
		HMO-Hi	Employee	12/31/59	F	19904	07/14/08	\$614.31	\$614.31	\$0.00	\$0.00
		HMO-Hi	Family	10/19/74	M	19962	05/08/06	\$1,720.07	\$669.32	\$630.45	\$420.30
		PPO	Employee	10/07/70	M	19901	01/21/97	\$669.32	\$669.32	\$0.00	\$0.00
		HMO-Hi	Employee	12/12/62	M	19943	10/29/90	\$614.31	\$614.31	\$0.00	\$0.00
		PPO	Employee	02/21/47	M	19950	03/06/00	\$669.32	\$669.32	\$0.00	\$0.00
		HMO-Hi	Employee	08/13/57	F	19943	08/13/98	\$614.31	\$614.31	\$0.00	\$0.00
		HMO-Hi	Family	9/9/1963	F	19943	1/3/2000	\$1,720.07	\$669.32	\$630.45	\$420.30
		HMO-Hi	Employee	09/11/73	F	19962	02/02/04	\$614.31	\$614.31	\$0.00	\$0.00
		HMO-Hi	Child	08/19/74	M	19962	02/28/00	\$982.90	\$669.32	\$188.15	\$125.43
		HMO-Hi	Employee	01/04/60	M	19947	08/23/04	\$614.31	\$614.31	\$0.00	\$0.00
		HMO-Hi	Family	07/25/60	M	19943	11/13/84	\$1,720.07	\$669.32	\$630.45	\$420.30
		PPO	Child	10/23/64	F	19936	12/02/85	\$1,070.91	\$669.32	\$240.95	\$160.64
		PPO	Employee	02/06/51	F	19943	5/1/2006	\$669.32	\$669.32	\$0.00	\$0.00
		HMO-Hi	Spouse	2/12/1968	M	19946	8/29/2005	\$1,412.91	\$669.32	\$446.15	\$297.44
		PPO	Employee	10/6/1958	F	19979	7/10/2007	\$669.32	\$669.32	\$0.00	\$0.00
		HMO-Hi	Employee	01/15/59	M	19963	04/05/80	\$614.31	\$614.31	\$0.00	\$0.00
		HMO-Hi	Employee	05/22/62	M	19963	6/25/2001	\$614.31	\$614.31	\$0.00	\$0.00
		HMO-Hi	Family	04/25/61	M	19943	10/15/2002	\$1,720.07	\$669.32	\$630.45	\$420.30
		PPO	Employee	11/23/55	M	19946	05/01/00	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Child	03/26/63	F	19901	11/20/2006	\$1,070.91	\$669.32	\$240.95	\$160.64
		PPO	Employee	08/21/52	M	19934	08/21/85	\$669.32	\$669.32	\$0.00	\$0.00
		HMO-Hi	Child	12/25/1971	F	19904	6/5/2006	\$1,720.07	\$669.32	\$630.45	\$420.30
		HMO-Hi	Employee	8/23/1985	M	19901	7/27/2009	\$614.31	\$614.31	\$0.00	\$0.00
		HMO-Hi	Employee	03/25/44	F	19934	01/07/03	\$614.31	\$614.31	\$0.00	\$0.00
		PPO	Spouse	07/09/75	M	19950	07/07/09	\$1,539.43	\$669.32	\$522.07	\$348.04
		PPO	Employee	02/26/46	M	19901	6/1/2001	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Child	07/01/76	F	19943	07/19/95	\$1,070.91	\$669.32	\$240.95	\$160.64
		PPO	Employee	01/29/63	M	19709	02/02/01	\$669.32	\$669.32	\$0.00	\$0.00
		HMO-Hi	Child	09/07/49	M	19946	10/23/00	\$982.90	\$669.32	\$188.15	\$125.43
		PPO	Employee	10/21/42	F	19943	06/18/04	\$669.32	\$669.32	\$0.00	\$0.00

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Employee Name	Position	Option	Coverage	DOB	Sex	Zip	Hire Date	Premium	Co. Share	Dep. Cont.	Emp. Share
		HMO-Hi	Employee	07/05/52	M	19943	10/16/00	\$614.31	\$614.31	\$0.00	\$0.00
		PPO	Family	12/19/80	M	19973	10/15/07	\$1,874.10	\$669.32	\$722.87	\$481.91
		PPO	Employee	11/04/78	M	19938	01/17/06	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	01/03/59	F	19952	9/4/2001	\$669.32	\$669.32	\$0.00	\$0.00
		HMO-Hi	Family	12/29/68	M	19904	09/21/95	\$1,720.07	\$669.32	\$630.45	\$420.30
		PPO	Employee	11/16/85	F	19950	9/27/2007	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Employee	10/18/62	F	19904	11/29/2005	\$669.32	\$669.32	\$0.00	\$0.00
		PPO	Family	04/16/61	F	19904	9/19/2007	\$1,874.10	\$669.32	\$722.87	\$481.91
								\$229,176.70	\$162,818.44	\$39,814.96	\$26,543.30
								12	12	12	12
								\$2,750,120.40	\$1,953,821.28	\$477,779.47	\$318,519.65

NOTES:

- Child is Employee & Child or children coverage
- Employee is Employee only coverage
- Family is Employee & Family coverage
- HMO-Hi is BCBSDE IPA High (100%) Active Employee
- HMO-Lo is BCBSDE IPA Low (80%) Active Employee
- PPO is PPO 100% Active employee
- Spouse is Employee & Spouse coverage
- BCBSDE is Blue Cross Blue Shield of Delaware, Inc.

Retiree Name	Option	Coverage	DOB	Sex	Zip	Retire Date	Premium	Co. Share	Dep. Cont.	Ret. Share	Comments
	MED	Spouse	3/14/1943	F	19904	12/13/2007	\$674.68	\$337.34	\$202.40	\$134.94	
	MED	Spouse	9/3/1934	M	19934	9/3/1994	\$674.68	\$337.34	\$202.40	\$134.94	
	PPO-R	Retiree	09/14/52	M	19943	09/18/79	\$669.32	\$669.32	\$0.00	\$0.00	
	PPO-R	Retiree	06/23/50	M	19943	10/03/77	\$669.32	\$669.32	\$0.00	\$0.00	
	MED	Spouse	9/21/1942	M	19977	9/16/2004	\$674.68	\$337.34	\$202.40	\$134.94	
	MED	SPOUSE	9/21/1941	M	19952	N/A	\$337.34	\$0.00	\$202.40	\$134.94	Spouse of non-Medicifill Retiree
	HMO-HIR	Retiree	7/14/1947	F	19952	7/31/2008	\$614.31	\$614.31	\$0.00	\$0.00	
	MED	Retiree	12/12/1931	F	19901	6/16/2000	\$337.34	\$337.34	\$0.00	\$0.00	
	MED	Spouse	10/16/1937	M	19707	08/01/95	\$674.68	\$337.34	\$202.40	\$134.94	
	MED	Retiree	9/26/1915	M	19904	6/1/1988	\$337.34	\$337.34	\$0.00	\$0.00	
	MED	Retiree	2/5/1936	M	19904	11/07/06	\$337.34	\$337.34	\$0.00	\$0.00	
	HMO-HIR	Retiree	06/23/47	F	19901	08/31/87	\$614.31	\$614.31	\$0.00	\$0.00	
	MED	SPOUSE		M	19901	N/A	\$337.34	\$0.00	\$202.40	\$134.94	Spouse of non-Medicifill Retiree
	HMO-HIR	Retiree	11/08/46	F	19963	09/29/93	\$614.31	\$614.31	\$0.00	\$0.00	
	MED	Retiree	10/14/1942	M	19901	2/1/2005	\$337.34	\$337.34	\$0.00	\$0.00	
	MED	Retiree	6/9/1930	M	19952	N/A	\$337.34	\$0.00	\$0.00	\$337.34	
	MED	Retiree	8/2/1928	F	19943	9/1/1993	\$337.34	\$337.34	\$0.00	\$0.00	
	PPO-R	Retiree	03/23/58	M	19904	09/21/77	\$669.32	\$669.32	\$0.00	\$0.00	
	MED	Spouse	5/10/1935	F	19943	9/1/1997	\$674.68	\$337.34	\$202.40	\$134.94	
	MED	Retiree	2/14/1926	F	19934	1/1/1988	\$337.34	\$337.34	\$0.00	\$0.00	
	MED	Spouse	10/4/1939	M	19952	3/1/2005	\$674.68	\$337.34	\$202.40	\$134.94	
	MED	Retiree	2/3/1924	F	19901	2/1/1990	\$337.34	\$337.34	\$0.00	\$0.00	
	HMO-HIR	Retiree	08/23/46	F	19962	12/04/89	\$614.31	\$614.31	\$0.00	\$0.00	
	HMO-HIR	Retiree	08/24/46	M	19901	09/11/00	\$614.31	\$614.31	\$0.00	\$0.00	
	MED	Retiree	3/3/1917	F	19964	1/1/1980	\$337.34	\$337.34	\$0.00	\$0.00	
	MED	Retiree	4/13/1943	F	19966	06/18/87	\$337.34	\$337.34	\$0.00	\$0.00	
	MED	Retiree	10/20/1931	M	19901	5/13/2000	\$337.34	\$337.34	\$0.00	\$0.00	
	HMO-HIR	Spouse	7/10/1948	F	19934	7/31/2003	\$1,412.91	\$669.32	\$446.15	\$297.44	
	MED	Retiree	6/27/1953	M	19901	6/30/2000	\$337.34	\$337.34	\$0.00	\$0.00	
	HMO-HIR	Retiree	09/21/53	F	19901	10/22/85	\$614.31	\$614.31	\$0.00	\$0.00	
	PPO-R	Retiree	06/27/53	F	19901	02/28/73	\$669.32	\$669.32	\$0.00	\$0.00	
	PPO-R	Retiree	07/27/50	M	19938	10/08/73	\$669.32	\$669.32	\$0.00	\$0.00	
	PPO-R	Retiree	1/21/1947	F	19943	07/31/07	\$669.32	\$669.32	\$0.00	\$0.00	
	MED	Retiree	3/17/1940	M	19934	3/1/2005	\$337.34	\$337.34	\$0.00	\$0.00	
	MED	Retiree	7/27/1939	F	19979	7/1/1997	\$337.34	\$337.34	\$0.00	\$0.00	
	MED	Retiree	7/2/1935	M	19979	8/1/1997	\$337.34	\$337.34	\$0.00	\$0.00	
	MED	Retiree	9/28/1933	M	19963	9/1/1992	\$337.34	\$337.34	\$0.00	\$0.00	
	MED	Retiree	4/17/1934	F	17516	4/1/1997	\$337.34	\$337.34	\$0.00	\$0.00	
	MED	SPOUSE		M	19901	N/A	\$337.34	\$0.00	\$202.40	\$134.94	Spouse of non-Medicifill Retiree
	HMO-HIR	Retiree	09/17/46	F	19901	9/17/2001	\$614.31	\$614.31	\$0.00	\$0.00	
	MED	Retiree	4/4/1920	M	19901	5/1/1993	\$337.34	\$337.34	\$0.00	\$0.00	
	MED	Retiree	6/23/1940	F	19901	08/12/98	\$337.34	\$337.34	\$0.00	\$0.00	
	HMO-HIR	Retiree	7/5/1955	M	19963	09/10/73	\$614.31	\$614.31	\$0.00	\$0.00	
	MED	Retiree	8/1/1929	F	19934	6/30/2000	\$337.34	\$337.34	\$0.00	\$0.00	
	MED	Spouse	2/17/1938	F	19934	2/1/2008	\$674.68	\$337.34	\$202.40	\$134.94	
	MED	Retiree	5/3/1928	M	19943	6/5/1993	\$337.34	\$337.34	\$0.00	\$0.00	
	PPO-R	Spouse	8/19/1950	M	19943	9/1/2005	\$1,539.43	\$669.32	\$522.07	\$348.04	
	PPO-R	Retiree	4/29/1947	F	19904	5/1/2001	\$669.32	\$669.32	\$0.00	\$0.00	

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Retiree Name	Option	Coverage	DOB	Sex	Zip	Retire Date	Premium	Co. Share	Dep. Cont.	Ret. Share	Comments
	MED	Retiree	3/22/1929	F	19963	4/28/2000	\$337.34	\$337.34	\$0.00	\$0.00	
	PPO-R	Retiree	5/2/1946	F	19904	9/1/2001	\$669.32	\$669.32	\$0.00	\$0.00	
	MED	Retiree	3/21/1941	F	19901	6/1/2006	\$337.34	\$337.34	\$0.00	\$0.00	
	MED	Retiree	11/18/1941	F	19963	4/1/2005	\$337.34	\$337.34	\$0.00	\$0.00	
	MED	Retiree	11/19/1928	M	19904	6/1/1983	\$337.34	\$337.34	\$0.00	\$0.00	
	MED	Retiree	12/11/1932	F	32159	1/1/1990	\$337.34	\$337.34	\$0.00	\$0.00	
	HMO-HR	Retiree	9/24/1955	M	19962	10/22/2001	\$614.31	\$614.31	\$0.00	\$0.00	
	MED	Retiree	11/14/1937	M	21636	12/1/1992	\$337.34	\$337.34	\$0.00	\$0.00	
	MED	Retiree	9/21/1925	M	19936	4/1/1991	\$337.34	\$337.34	\$0.00	\$0.00	
	MED	Retiree	4/1/1932	F	19904	6/30/2000	\$337.34	\$337.34	\$0.00	\$0.00	
	MED	Retiree	2/20/1940	M	19904	06/01/94	\$337.34	\$337.34	\$0.00	\$0.00	
	MED	Retiree	12/12/1931	M	19964	7/1/1992	\$337.34	\$337.34	\$0.00	\$0.00	
	MED	Spouse	7/21/1937	M	19938	1/7/2000	\$674.68	\$674.68	\$202.40	\$134.94	
	PPO-R	Retiree	7/17/1947	F	19943	07/13/07	\$669.32	\$669.32	\$0.00	\$0.00	
	PPO-R	Retiree	10/29/46	F	19943	01/02/80	\$669.32	\$669.32	\$0.00	\$0.00	
	MED	Retiree	1/17/1944	M	19943	2/29/2004	\$337.34	\$337.34	\$0.00	\$0.00	
	MED	Retiree	7/31/1923	F	19934	6/30/2000	\$337.34	\$337.34	\$0.00	\$0.00	
	MED	Retiree	1/25/1924	F	19901	6/30/2000	\$337.34	\$337.34	\$0.00	\$0.00	
	MED	Retiree	5/16/1941	M	30710	5/31/2007	\$337.34	\$337.34	\$0.00	\$0.00	
	PPO-R	SPOUSE	12/27/1945	F	30710	N/A	\$669.32	\$0.00	\$401.59	\$267.73	Spouse of Medicifill Retiree
	HMO-HR	Retiree	06/28/49	F	19943	10/17/83	\$614.31	\$614.31	\$0.00	\$0.00	
	MED	Retiree	2/13/1933	F	19963	4/30/2000	\$337.34	\$337.34	\$0.00	\$0.00	
	MED	Retiree	8/12/1942	F	19904	08/06/79	\$337.34	\$337.34	\$0.00	\$0.00	
	MED	Retiree	11/27/1936	M	19903	1/1/1998	\$337.34	\$337.34	\$0.00	\$0.00	
	MED	Retiree	7/3/1942	F	19904	12/31/2004	\$337.34	\$337.34	\$0.00	\$0.00	
	MED	Retiree	8/22/1933	F	19904	9/1/1998	\$337.34	\$337.34	\$0.00	\$0.00	
	MED	Retiree	5/20/1940	M	19934	6/30/2000	\$337.34	\$337.34	\$0.00	\$0.00	
	MED	Retiree	1/26/1947	F	19952	11/1/2005	\$337.34	\$337.34	\$0.00	\$0.00	
	MED	Retiree	1/5/1929	F	19901	6/1/1992	\$337.34	\$337.34	\$0.00	\$0.00	
	MED	Retiree	7/31/1942	M	19963	12/31/06	\$337.34	\$337.34	\$0.00	\$0.00	
	PPO-R	Retiree	09/10/53	F	19980	6/17/2002	\$669.32	\$669.32	\$0.00	\$0.00	
	MED	Retiree	7/6/1941	F	19962	08/31/07	\$337.34	\$337.34	\$0.00	\$0.00	
	HMO-LoR	Retiree	7/25/1947	F	19952	6/1/2001	\$568.13	\$568.13	\$0.00	\$0.00	
	MED	Retiree	5/24/1927	F	19946	6/1/1987	\$337.34	\$337.34	\$0.00	\$0.00	
	PPO-R	Retiree	12/13/1946	M	19901	12/31/2008	\$669.32	\$669.32	\$0.00	\$0.00	
	PPO-R	Retiree	7/10/1948	M	19953	10/1/2001	\$669.32	\$669.32	\$0.00	\$0.00	
	HMO-HR	Retiree	01/23/51	M	19938	08/02/76	\$614.31	\$614.31	\$0.00	\$0.00	
	MED	Retiree	12/28/1936	F	19971	3/31/2000	\$337.34	\$337.34	\$0.00	\$0.00	
	MED	Retiree	6/3/1935	F	19938	08/24/81	\$337.34	\$337.34	\$0.00	\$0.00	
	HMO-HR	Retiree	12/13/51	M	19943	09/31/77	\$614.31	\$614.31	\$0.00	\$0.00	
	MED	Spouse	10/29/1940	F	19977	2/1/1997	\$674.68	\$674.68	\$202.40	\$134.94	
	PPO-R	Retiree	7/24/1946	M	19962	8/1/2001	\$669.32	\$669.32	\$0.00	\$0.00	
	MED	SPOUSE	8/29/1939	F	19962	N/A	\$337.34	\$0.00	\$202.40	\$134.94	Spouse of non-Medicifill Retiree
	MED	Spouse	12/26/1940	F	19977	6/30/2000	\$674.68	\$337.34	\$202.40	\$134.94	
	PPO-R	Retiree	6/13/1920	M	19901	7/1/1985	\$337.34	\$337.34	\$0.00	\$0.00	
	MED	Retiree	12/18/1944	M	19904	02/28/06	\$669.32	\$669.32	\$0.00	\$0.00	
	MED	Retiree	5/10/1929	F	19901	6/30/2000	\$337.34	\$337.34	\$0.00	\$0.00	
	PPO-R	Spouse	7/28/1951	M	19904	01/03/07	\$1,539.43	\$669.32	\$522.07	\$348.04	

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Retiree Name	Option	Coverage	DOB	Sex	Zip	Retire Date	Premium	Co. Share	Dep. Cont.	Ret. Share	Comments
	PPO-R	Retiree	09/06/48	M	19903	08/06/90	\$669.32	\$669.32	\$0.00	\$0.00	
	HMO-HIR	Retiree	11/29/1958	M	19904	07/05/07	\$614.31	\$614.31	\$0.00	\$0.00	
	PPO-R	Retiree	05/02/49	M	19901	06/18/73	\$669.32	\$669.32	\$0.00	\$0.00	
	PPO-R	Retiree	08/28/47	M	19901	05/22/89	\$669.32	\$669.32	\$0.00	\$0.00	
	MED	Retiree	7/10/1939	M	19901	06/01/88	\$337.34	\$337.34	\$0.00	\$0.00	
	PPO-R	Retiree	8/15/1945	M	19952	10/31/08	\$669.32	\$669.32	\$0.00	\$0.00	
	MED	Spouse	10/1/1933	M	19952	1/3/1995	\$674.68	\$337.34	\$202.40	\$134.94	
	MED	Retiree	9/9/1943	F	19952	10/1/1998	\$337.34	\$337.34	\$0.00	\$0.00	
							\$52,744.85	\$44,194.28	\$4,927.94	\$3,622.63	
							12	12	12	12	
							\$632,938.20	\$530,331.36	\$59,135.26	\$43,471.58	

NOTES:

- Retiree is Retiree only coverage
- HMO-HIR is BCBSDE IPA High (100%) Retired Employee
- HMO-LoR is BCBSDE IPA Low (80%) Retired Employee
- MED is BCBSDE Medicare Supplement
- MED\*COBRA is BCBSDE Medicare for COBRA eligible participant
- PPO-R is PPO 100% Retired employee
- Spouse is Retiree & Spouse coverage
- SPOUSE is Spouse only coverage
- BCBSDE is Blue Cross Blue Shield of Delaware, Inc.

