		Current			
Carrier Name		Blue Shield		Anthem	
Plan Name		PPO		HDHP 1500	
Network		Blue Shield	Non-PPO	Prudent Buyer PPO	Non-PPO
General Plan Information					
Annual Deductible/Individual		$250	$450	$1,500	$1,500
Annual Deductible/Family		$500	$900	$3,000	$3,000
Coinsurance		20%	50%	10%	30%
Office Visit/Exam		$20 copay	50%	10%	30%
Outpatient Specialist Visit		$20 copay	50%	10%	30%
Annual Out-of-Pocket Limit/Individual		$2,500	$5,000	$2,500	$5,000
Annual Out-of-Pocket Limit/Family		$5,000	$10,000	$5,000	$10,000
Outpatient Services					
Preventive Services					
Most ACA-Mandated Preventive Care Services		No charge (deductible waived)	Not covered	No charge (deductible waived)	30%
Diagnostic X-Ray and Lab Tests		20%	50%	No charge (10% non-preventive)	30%
Maternity Care					
Pregnancy and Maternity Pre-Natal Care		No charge (deductible waived)	Not covered	10%	30%
Inpatient Hospital Services					
Inpatient Hospitalization		20%	$500 copay + 50%	10%	30% ($1,000/day non-emergency)
Surgical Services					
Outpatient Facility Charge		20%	50%	10%	30% ($350/day max)
Emergency Services					
Emergency Room Copay (Waived if Admitted)		$75 copay + 20%	$75 copay + 20%	10%	10%
Ambulance					
Air & Ground		20%	20%	10%	10% (30% non-emergency)
Urgent Care					
Urgent Care Facility		See EOC	See EOC	10%	30%
Mental Health & Substance Abuse Benefits					
Inpatient Care		20%	$500 copay + 50%	10%	30% ($1,000/day non-emergency)
Outpatient Care		$20 copay	50%	10%	30%
Prescription Drug Benefits					
Rx Deductible		$0	N/A	Medical deductible applies	Medical deductible applies
Rx Annual Out-of-Pocket Limit/Individual		$2,500	N/A	Included in Medical OOP	Included in Medical OOP
Rx Drug Annual Out-of-Pocket Limit/Family		$5,000	N/A	Included in Medical OOP	Included in Medical OOP
Generic		$15 copay ($5 Costco)	Not covered	$10 copay	$10 copay + 50%
Brand (Formulary/Preferred)		$30 copay ($20 Costco)	Not covered	$30 copay	$30 copay + 50%
Brand (Non-Formulary/Non-preferred)		$45 copay ($30 Costco)	Not covered	$50 copay	$50 copay + 50%
Specialty		See EOC	Not covered	30% up to $150/Rx	Not covered
Number of Days Supply		31 days	N/A	30 days	30 days
Mail Order					
Generic		$15 copay	Not covered	$10 copay	Not covered
Brand (Formulary/Preferred)		$35 copay	Not covered	$60 copay	Not covered
Brand (Non-Formulary/Non-preferred)		$65 copay	Not covered	$100 copay	Not covered
Number of Days Supply for Mail Order		90 days	N/A	90 days	N/A
Other Services and Supplies					
Durable Medical Equipment		20%	50%	50%	50%
Home Health Care		20% (100 visits/year)	50% (100 visits/year)	10% (100 visits/year)	30% (100 visits/year)
Skilled Nursing or Extended Care Facility		20% (100 days/year)	50% (100 days/year)	10% (100 days/year)	30% (100 days/year)
Hospice Care		20%	50%	10%	30%
Chiropractic Services		$10 copay (30 visits/year)	$10 copay (30 visits/year)	10% (30 visits/year)	30% (20 visits/year)
Acupuncture		See EOC	See EOC	10% (20 visits/year)	30% (20 visits/year)
Outpatient Rehabilitative Therapy Services					
Physical & Occupational		20%	50%	10%	30%
Speech		20%	50%	10%	30%
Rate Structure	**Subs**	**Current**	**County "Renewal"**	**6 Months**	**18 Month**
Employee Only	9	$595.14	$611.10	$785.55	$837.92
Employee + 1	4	$1,080.96	$1,109.96	$1,571.09	$1,675.84
Employee + Family	4	$1,620.58	$1,664.04	$2,042.42	$2,178.59
Monthly Premium		**$16,162.42**	**$16,595.90**	**$21,523.99**	**$22,959.00**
Annual Premium		**$193,949.04**	**$199,150.80**	**$258,287.88**	**$275,508.00**

		Current		Ameritas	
Carrier Name		Delta Dental		Ameritas	
Rate Guarantee		7/1/2023		1 year	
Plan Name		DPPO		DPPO Plan 2	
Network		Delta	Non-PPO	Ameritas	Non-PPO
General Plan Information					
Annual Deductible/Individual		$25		$25	
Annual Deductible/Family		$75		$75	
Annual Plan Maximum		$2,500		$1,500	
Preventive Max Waiver		Included		-	
Annual Maximum Rollover		-		$250/year up to $1k	
Eye Care		-		$100 Vision Benefit	
Waiting Period		TBD		None	
Out-of-Network Reimbursement		% UCR		Max. Allowable Charge	
Covered Services					
Diagnostic and Preventive					
Diagnostic and Preventive		No charge	0%	No charge	0%
Basic Services					
Basic		No charge	0%	No charge	0%
Sealants		No charge	0%	No charge	0%
Endodontic Treatment		No charge	0%	No charge	0%
Periodontic Treatment		No charge	0%	No charge	0%
Major Services					
Major		40%	40%	40%	40%
Prosthodontics		40%	40%	40%	40%
Implants		40%	40%	Not covered	
Orthodontia Services					
Lifetime Maximum		$2,500		$1,500	
Orthodontia (Child)		50%		50%	
Orthodontia (Adult)		50%		50%	
Rate Structure	**Subs**	**Dental + Vision**			
Employee Only	9	$46.30		$32.48	
Employee + 1	1	$86.90		$65.76	
Employee + Family	4	$136.68		$119.96	
Monthly Premium		**$1,050.32**		**$837.92**	
Annual Premium		**$12,603.84**		**$10,055.04**	

		Current		Option 3	
Carrier Name		EyeMed		Ameritas (VSP)	
Rate Guarantee		7/1/2023		2 years	
Plan Name		EyeMed Vision Plan		Plan 3 ($150)	
Network		Insight Network	Non-Network	VSP Choice	Non-Network
General Plan Information					
Copay					
Examination		$20 copay	$50 benefit	$20 copay	$45 benefit
Materials		$20 (lenses only)	N/A	$20 copay	$20 copay
Benefit Frequency					
Examination		12 months		12 months	
Lenses		12 months		12 months	
Contacts		12 months		12 months	
Frames		24 months		12 months	
Covered Services					
Lenses					
Single Vision Lens		$20 copay	$45 benefit	$20 copay	$30 benefit
Bifocal Lens		$20 copay	$65 benefit	$20 copay	$50 benefit
Trifocal Lens		$20 copay	$80 benefit	$20 copay	$65 benefit
Standard Progressive		$75 copay	$65 benefit	$20 copay	$50 benefit
Contact Lenses					
Fit-and-Follow-Up		Up to $40 copay	No benefit	Up to $60 copay	No benefit
Medically Necessary		No charge	$210 benefit	No charge	$210 benefit
Elective		$150 allowance	$100 benefit	$150 allowance	$120 benefit
Frames		$150 allowance	$80 benefit	$150 allowance	$70 benefit
Rate Structure	**Subs**				
Employee Only	9			$7.12	
Employee + 1	4			$14.60	
Employee + Family	4			$21.92	
Monthly Premium		**$0.00**		**$210.16**	
Annual Premium		**$0.00**		**$2,521.92**	
% Change Over Current					
$ Change Over Current				**$2,521.92**	

	Current	Option 1	Option 3
Carrier Name	**Standard**	**Standard**	**Hartford**
Rate Guarantee	N/A	3 years	3 years
Plan Name	Group Life/AD&D	$50k Flat	$50k Flat
Life-AD&D Benefits			
Class 1: All Directors	$50k flat	$50k Flat	$50k Flat
Class 2: All Managers	$40k flat	$50k Flat	$50k Flat
Class 3: All Other Employees	$10k flat	$50k Flat	$50k Flat
Dependent Life			
Spouse			
Child			
Guaranteed Issue			
All Classes	Full benefit	Full benefit	Full benefit
Plan Features			
Accelerated Benefit	Included	Included	Included
Waiver of Premium	Included	Included	Included
Conversion	Included	Included	Included
Additional Benefits			
Adaptive Home & Vehicle	-	-	Included
Child Care	Included	Included	Included
Common Carrier	-	-	-
Higher Education	Included	Included	Included
Spousal Retraining (Education)	Included	Included	Included
Reduction of Benefits Schedule			
65 - 69		No reduction	No reduction
70 - 74		35% reduction	50% reduction
75 - 79		50% reduction	No further reduction
Rate Structure	**County of Kings**		
Group Life Volume	$332,500	$1,250,000	$1,250,000
Premium Rate (Basic Life) per $1,000	$0.120	$0.209	$0.155
Premium Rate (AD&D) per $1,000		$0.020	$0.020
Monthly Premium	**$39.90**	**$286.25**	**$218.75**
Annual Premium	**$478.80**	**$3,435.00**	**$2,625.00**

		Current	Option 2	Option 7
Carrier Name		Standard	Standard	Hartford
Rate Guarantee		N/A	3 years	2 years
Plan Name		LTD	LTD 5	LTD 6
General Plan Information				
Elimination Period				
Class 1: Management		30 days	365 days	180 days
Class 2: All Other Members			365 days	180 days
Benefit Percentage				
Class 1: Management		60%	60%	60%
Class 2: All Other Members			60%	60%
Maximum Monthly Benefit				
Class 1: Management		$10,000	$6,000	$9,000
Class 2: All Other Members			$6,000	$9,000
Maximum Benefit Period				
Class 1: Management		Age 65	SSNRA	SSNRA
Class 2: All Other Members			SSNRA	SSNRA
Own Occupation Period				
Class 1: Management		36 months	24 months	36 months
Class 2: All Other Members			24 months	36 months
Pre-Existing Condition Limitations		3/12	3/12	3/12
Rate Structure	**Subs**	**County of Kings**		
LTD Volume		$22,192	$97,963	$97,963
Premium Rate (per $100)	25	3 x $11 PEPM	$0.355	$0.262
LTD Monthly Premium		**$33.00**	**$347.77**	**$256.66**
LTD Annual Premium		**$396.00**	**$4,173.22**	**$3,079.96**