Employer Group Plans | 2019 Plan Benefit Highlights

FOR A COMPLETE LIST OF BENEFITS UNDER EACH PLAN, REFER TO THE HEALTH PLAN BENEFITS AND COVERAGE MATRIX. PLEASE CALL 1-888-371-3060 TO REQUEST A COPY, OR VISIT: www.cchphealthplan.com/EGP

						PLANS AVAILABLE OUTSIDE AND INSIDE COVERED CALIFORNIA				
Plan Name	Ruby 10 HMO Platinum	Ruby 20 HMO Platinum	Ruby 40 HMO Platinum	Opal 25 HMO Gold	Opal 50 HMO Silver	Platinum 90 HMO 0/15 + Child Dental	Gold 80 HMO 0/30 + Child Dental	Silver 70 HMO 2000/45 + Child Dental	Bronze 60 HMO 6300/75 + Child Dental	Bronze 60 HDHP HMO 6000/40% + Child Dental
Metal Level / Actuarial Value %*	Platinum / 91.97%	Platinum / 91.26 %	Platinum / 89.64%	Gold / 80.8 %	Silver / 71.79%	Platinum / 88.9%	Gold / 78.1%	Silver / 71.6%	Bronze / 60.9%	Bronze / 61.6%
SERVICES AND FEATURES										
Annual Deductible	$0	$0	$0	Individual $1,500 / Family $3,000 (A)	Individual $3,000 / Family $6,000 (A) Combined Medical / Rx	$0	$0	Individual $2,000 / Family $4,000 (A)	Individual $6,300 / Family $12,600 (A)	Individual $6,000/ Family $12,000 Combined Medical/Rx
Out–of–Pocket Limit On Expenses	Individual $4,250 / Family $8,500	Individual $4,000 / Family $8,000	Individual $6,850 / Family $13,700	Individual $4,000 / Family $8,000	Individual $7,500 / Family $15,000	Individual $3,350 / Family $6,700	Individual $7,200/ Family $14,400	Individual $7,550/ Family $15,100	Individual $7,550/ Family$15,100	Individual $6,650/ Family $13,300
LIFETIME MAXIMUMS	No Limit					No Limit				
PROFESSIONAL SERVICES	**Member Cost Share**					**Member Cost Share**				
Preventive Care/ Screening/Immunization	$0 Copay					$0 Copay				
Primary Care Visit to Treat an Injury or Illness	$10 Copay	$20 Copay	$40 Copay	$0 Copay for 1st (3) Non-Preventive PCP Visits (Deductible Does Not Apply) Then $25 Copay (After Deductible)	$0 Copay for 1st (3) Non-Preventive PCP Visits (Deductible Does Not Apply) Then $50 Copay (After Deductible)	$15 Copay	$30 Copay	$45 Copay	$75 Copay (Deductible Applies after 1st 3 non-preventive visits)*	40% Coinsurance (After Deductible)
Specialist Visit	$35 Copay	$40 Copay	$50 Copay	$25 Copay (After Deductible)	$50 Copay (After Deductible)	$30 Copay	$55 Copay	$80 Copay	$105 Copay (Deductible Applies after 1st 3 non-preventive visits)*	40% Coinsurance (After Deductible)
Maternity Care - Preconception/ Prenatal/Postnatal Care	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Delivery and all Inpatient Services (Hospital Services)	$150 Copay Per Day (Up to First 5 Days)	$150 Copay Per Day (Up to First 5 Days)	$250 Copay Per Day (Up to First 5 Days)	$150 Copay Per Day (Up to First 5 Days) (After Deductible)	$250 Copay Per Day (Up to First 5 Days) (After Deductible)	$250 per day (Up to the first Five Days)	$600 per day (Up to the first Five Days)	20% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met	40% Coinsurance (After Deductible)
Delivery and all Inpatient Services (Professional Services)	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	20% Coinsurance	Full Cost Until Out-of-Pocket is Met	40% Coinsurance (After Deductible)
OUTPATIENT SERVICES										
Laboratory Tests & X-Rays	$10 Copay	$10 Copay	$10 Copay	$0 Copay (After Deductible)	Laboratory: $25 Copay (After Deductible) X-Ray: $40 Copay (After Deductible)	Laboratory: $15 Copay X-Ray: $30 Copay	Laboratory: $35 Copay X-Ray: $55 Copay	Laboratory: $40 Copay X-Ray: $75 Copay	Laboratory: $40 Copay X-Ray: Full Cost Until Out-of-Pocket is Met	40% Coinsurance (After Deductible)
Imaging (CT/PET Scans, MRIs)	$150 Copay	$150 Copay	$150 Copay	$150 Copay (After Deductible)	$250 Copay (After Deductible)	$75 Copay	$275 Copay	$300 Copay	Full Cost Until Out-of-Pocket is Met	40% Coinsurance (After Deductible)
Surgery - Facility Fee (e.g., Ambulatory Surgery Center)	$75 Copay (Chinese Hospital) / $225 Copay (Other Contracted Facilities)	$75 Copay (Chinese Hospital) / $225 Copay (Other Contracted Facilities)	$200 Copay (Chinese Hospital) / $600 Copay (Other Contracted Facilities)	$50 Copay (Chinese Hospital) / $150 Copay (Other Contracted Facilities) (After Deductible)	$75 Copay (Chinese Hospital) / $225 Copay (Other Contracted Facilities) (After Deductible)	$100 Copay	$300 Copay	20% Coinsurance	Full Cost Until Out-of-Pocket is Met	40% Coinsurance (After Deductible)
Physician/Surgeon Fees	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$25 Copay	$40 Copay	20% Coinsurance	Full Cost Until Out-of-Pocket is Met	40% Coinsurance (After Deductible)

Footnotes: * Actuarial Value is the percentage of total average costs for covered benefits that a plan will cover.
Preventive care are not subject to the deductible.
(1) Medical / RX cost-sharing contributes toward annual deductible.
(A) You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use, unless the service is not subject to the deductible. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st).

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HOSPITALIZATION SERVICES	**Member Cost Share**					**Member Cost Share**				
Facility Fee (e.g., Hospital Room)	$150 Copay Per Day (Chinese Hospital) / $450 Copay Per Day (Other Contracted Facilities) (Up to First 5 days)	$150 Copay Per Day (Chinese Hospital) / $450 Copay Per Day (Other Contracted Facilities) (Up to First 5 days)	$250 Copay Per Day (Chinese Hospital) / $750 Copay Per Day (Other Contracted Facilities) (Up to First 5 days)	$150 Copay Per Day (Chinese Hospital) / $450 Copay Per Day (Other Contracted Facilities) (Up to First 5 days) (After Deductible)	$250 Copay Per Day (Chinese Hospital) / $750 Copay Per Day (Other Contracted Facilities) (Up to First 5 days) (After Deductible)	$250 Per Day (Up To First 5 Days)	$600 Per Day (Up To First 5 Days)	20% Coinsurance (After Deductible)	Full Cost Until Out-of-Pocket is Met	40% Coinsurance (After Deductible)
Physician/Surgeon Fees	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	20% Coinsurance	Full Cost Until Out-of-Pocket is Met	40% Coinsurance (After Deductible)
EMERGENCY HEALTH COVERAGE										
Emergency Room Services	$150 Copay	$150 Copay	$150 Copay	$100 Copay (After Deductible)	$300 Copay (After Deductible)	$150 Copay	$325 Copay	$350 Copay	Full Cost Until Out-of-Pocket is Met	40% Coinsurance (After Deductible)
Professional Services	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay (After Deductible)
Urgent Care Center	$10 Copay	$20 Copay	$40 Copay	$25 Copay (After Deductible)	$50 Copay (After Deductible)	$15 Copay	$30 Copay	$45 Copay	$75 Copay (Deductible Applies After 1st (3) Non-Preventive Visits)	40% Coinsurance (After Deductible)
PRESCRIPTION DRUG COVERAGE										
Annual Rx Deductible	$0	$0	$0	Individual $250 / Family $500	Individual $3,000 / Family $6,000 (A) Combined Medical / Rx	$0	$0	Individual $200 / Family $400	Individual $500 / Family $1,000	Individual $6,000/ Family $12,000 Combined Medical/Rx
Tier 1 Drugs (30-Day Supply)	$5 Copay	$5 Copay	$5 Copay	$15 Copay	$15 Copay	$5 Copay	$ 15 Copay	$ 15 Copay (After Rx Deductible)	Full Cost up to $500 per Prescription Until Out-of-Pocket is Met (After Rx Deductible)	40% Coinsurance up to $500 per Prescription (After Deductible)
Tier 2 Drugs (30-Day Supply)	$15 Copay	$15 Copay	$15 Copay	$50 Copay (After Rx Deductible)	$50 Copay (After Deductible)	$15 Copay	$55 Copay	$ 55 Copay (After Rx Deductible)	Full Cost up to $500 per Prescription Until Out-of-Pocket is Met (After Rx Deductible)	40% Coinsurance up to $500 per Prescription (After Deductible)
Tier 3 Drugs (30-Day Supply)	$25 Copay	$25 Copay	$25 Copay	$70 Copay (After Rx Deductible)	$70 Copay (After Deductible)	$25 Copay	$75 Copay	$85 Copay (After Rx Deductible)	Full Cost up to $500 per Prescription Until Out-of-Pocket is Met (After Rx Deductible)	40% Coinsurance up to $500 per Prescription (After Deductible)
Tier 4 Drugs (30-Day Supply)	10% Coinsurance up to $250 per Prescription	10% Coinsurance up to $250 per Prescription	10% Coinsurance up to $250 per Prescription	20% Coinsurance up to $250 per Prescription (After Rx Deductible)	20% Coinsurance up to $250 per Prescription (After Rx Deductible)	10% Coinsurance up to $250 per prescription	20% Coinsurance up to $250 per Prescription	20% Coinsurance Up to $250 Per Prescription (After Rx Deductible)	Full Cost up to $500 per Prescription Until Out-of-Pocket is Met (After Rx Deductible)	40% Coinsurance up to $500 per Prescription (After Deductible)
PEDIATRIC VISION AND DENTAL (Included in Plan)										
Child Needs Eye Care (Ages 0-18)										
Eye Exam (1 Per Calendar Year)	$0 Copay					$0 Copay				
Eyewear (Frames) (1 Pair Per Calendar Year)	$0 Copay					$0 Copay				
Eyewear (Lenses) (1 Pair Per Calendar Year) (Contact Lenses Provided in Lieu of Glasses)	Single Vision / Bi-focal / Tri-focal / Lenticular No Cost Share					Single Vision / Bi-focal / Tri-focal / Lenticular No Cost Share				
Eyewear (Contact Lenses)	$0 Copay					$0 Copay				
Pediatric Dental (Ages 0-18)	Included in Plan. See Dental Summary Page.					Included in Plan. See Dental Summary Page.				

How to Contact Us? **CCHP Sales Department | 1-888-681-3888 | sales@cchphealthplan.com | 445 Grant Avenue, Suite 700 | San Francisco, CA 94108**

Employer Group Plans | 公司團體計劃

2019 Monthly Rates | *San Francisco County* | 三藩市縣

January 1 - December 31, 2019 | 只適用於 1/1/19 – 12/31/19

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	Ruby 10 HMO Platinum	Ruby 20 HMO Platinum	Ruby 40 HMO Platinum	Opal 25 HMO Gold	Opal 50 HMO Silver
AGE / 年齡	**RATE / 月費**	**RATE / 月費**	**RATE / 月費**	**RATE / 月費**	**AGE / 年齡**
0-14	321.70	315.43	297.63	254.92	227.14
15	350.30	343.47	324.08	277.58	247.33
16	361.23	354.19	334.20	286.24	255.05
17	372.16	364.91	344.31	294.91	262.77
18	383.94	376.46	355.21	304.24	271.09
19	395.71	388.00	366.10	313.57	279.40
20	407.91	399.96	377.38	323.23	288.01
21	420.52	412.33	389.05	333.23	296.92
22	420.52	412.33	389.05	333.23	296.92
23	420.52	412.33	389.05	333.23	296.92
24	420.52	412.33	389.05	333.23	296.92
25	422.21	413.98	390.61	334.56	298.11
26	430.62	422.23	398.39	341.23	304.05
27	440.71	432.12	407.73	349.22	311.17
28	457.11	448.21	422.90	362.22	322.75
29	470.57	461.40	435.35	372.88	332.25
30	477.29	468.00	441.58	378.21	337.00
31	487.39	477.89	450.91	386.21	344.13
32	497.48	487.79	460.25	394.21	351.26
33	503.79	493.97	466.09	399.21	355.71
34	510.51	500.57	472.31	404.54	360.46
35	513.88	503.87	475.42	407.21	362.84
36	517.24	507.17	478.54	409.87	365.21
37	520.61	510.47	481.65	412.54	367.59
38	523.97	513.77	484.76	415.20	369.96
39	530.70	520.36	490.99	420.53	374.71
40	537.43	526.96	497.21	425.87	379.46
41	547.52	536.86	506.55	433.86	386.59
42	557.19	546.34	515.50	441.53	393.42
43	570.65	559.54	527.95	452.19	402.92
44	587.47	576.03	543.51	465.52	414.80
45	607.24	595.41	561.79	481.18	428.75
46	630.78	618.50	583.58	499.84	445.38
47	657.28	644.48	608.09	520.84	464.09
48	687.56	674.16	636.10	544.83	485.47
49	717.41	703.44	663.73	568.49	506.55
50	751.05	736.43	694.85	595.15	530.30
51	784.28	769.00	725.59	621.47	553.76
52	820.86	804.87	759.43	650.46	579.59
53	857.87	841.16	793.67	679.79	605.72
54	897.82	880.33	830.63	711.44	633.93
55	937.77	919.50	867.59	743.10	662.13
56	981.08	961.97	907.66	777.42	692.72
57	1024.81	1004.85	948.12	812.08	723.60
58	1071.49	1050.62	991.31	849.07	756.55
59	1094.62	1073.30	1012.71	867.39	772.88
60	1141.30	1119.07	1055.89	904.38	805.84
61	1181.67	1158.65	1093.24	936.37	834.35
62	1208.16	1184.63	1117.75	957.37	853.05
63	1241.38	1217.21	1148.49	983.69	876.51
64+	1261.56	1236.99	1167.15	999.69	890.76

Employer Group Plans | 公司團體計劃

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	PLANS AVAILABLE OUTSIDE AND INSIDE COVERED CALIFORNIA (SHOP) 可通過或不通過投保加州市場選擇這些醫療計劃(SHOP)				
	Platinum90 HMO 0/15 + Child Dental	Gold80 HMO 0/30 + Child Dental	Silver70 HMO 2000/45 + Child Dental	Bronze60 HMO 6300/75 + Child Dental	Bronze60 HDHP 6300/40% + Child Dental
AGE/年齡	**RATE/月費**	**RATE/月費**	**RATE/月費**	**RATE/月費**	**RATE/月費**
0-14	314.61	284.44	237.07	186.52	184.65
15	342.58	309.72	258.14	203.10	201.07
16	353.27	319.39	266.20	209.44	207.34
17	363.96	329.05	274.26	215.77	213.62
18	375.48	339.46	282.94	222.60	220.38
19	386.99	349.87	291.61	229.43	227.13
20	398.92	360.66	300.60	236.50	234.13
21	411.25	371.81	309.90	243.81	241.37
22	411.25	371.81	309.90	243.81	241.37
23	411.25	371.81	309.90	243.81	241.37
24	411.25	371.81	309.90	243.81	241.37
25	412.90	373.30	311.14	244.79	242.34
26	421.12	380.73	317.33	249.66	247.17
27	430.99	389.66	324.77	255.52	252.96
28	447.03	404.16	336.86	265.02	262.37
29	460.19	416.06	346.77	272.83	270.10
30	466.77	422.00	351.73	276.73	273.96
31	476.64	430.93	359.17	282.58	279.75
32	486.51	439.85	366.61	288.43	285.55
33	492.68	445.43	371.26	292.09	289.17
34	499.26	451.38	376.22	295.99	293.03
35	502.55	454.35	378.69	297.94	294.96
36	505.84	457.33	381.17	299.89	296.89
37	509.13	460.30	383.65	301.84	298.82
38	512.42	463.28	386.13	303.79	300.75
39	519.00	469.22	391.09	307.69	304.62
40	525.58	475.17	396.05	311.59	308.48
41	535.45	484.10	403.49	317.44	314.27
42	544.91	492.65	410.61	323.05	319.82
43	558.07	504.55	420.53	330.85	327.55
44	574.52	519.42	432.93	340.61	337.20
45	593.85	536.89	447.49	352.07	348.55
46	616.88	557.72	464.85	365.72	362.06
47	642.79	581.14	484.37	381.08	377.27
48	672.40	607.91	506.68	398.63	394.65
49	701.60	634.31	528.68	415.94	411.79
50	734.50	664.05	553.48	435.45	431.10
51	766.99	693.43	577.96	454.71	450.16
52	802.77	725.77	604.92	475.92	471.16
53	838.96	758.49	632.19	497.38	492.40
54	878.03	793.82	661.63	520.54	515.34
55	917.10	829.14	691.07	543.70	538.27
56	959.46	867.43	722.99	568.82	563.13
57	1002.23	906.10	755.22	594.17	588.23
58	1047.88	947.37	789.62	621.24	615.02
59	1070.50	967.82	806.66	634.65	628.30
60	1116.15	1009.09	841.06	661.71	655.09
61	1155.63	1044.79	870.81	685.11	678.26
62	1181.53	1068.21	890.33	700.47	693.47
63	1214.02	1097.58	914.82	719.74	712.54
64+	1233.75	1115.43	929.70	731.43	724.11

CCHP Health Plan 健華計人劃保

Employer Group Plans | 公司團體計劃

2019 Monthly Rates | *N. San Mateo County* | 北聖馬刁縣

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AGE/年齡	**RATE/月費**	**RATE/月費**	**RATE/月費**	**RATE/月費**	**AGE/年齡**
0-14	347.44	340.67	321.44	275.31	245.32
15	378.32	370.95	350.01	299.79	267.12
16	390.13	382.53	360.93	309.14	275.46
17	401.94	394.11	371.86	318.50	283.80
18	414.65	406.58	383.62	328.58	292.78
19	427.37	419.05	395.39	338.65	301.75
20	440.54	431.96	407.57	349.09	311.05
21	454.16	445.32	420.18	359.89	320.67
22	454.16	445.32	420.18	359.89	320.67
23	454.16	445.32	420.18	359.89	320.67
24	454.16	445.32	420.18	359.89	320.67
25	455.98	447.10	421.86	361.33	321.96
26	465.06	456.01	430.26	368.52	328.37
27	475.96	466.69	440.35	377.16	336.07
28	493.68	484.06	456.73	391.20	348.57
29	508.21	498.31	470.18	402.71	358.83
30	515.48	505.44	476.90	408.47	363.97
31	526.38	516.12	486.99	417.11	371.66
32	537.28	526.81	497.07	425.75	379.36
33	544.09	533.49	503.37	431.14	384.17
34	551.36	540.62	510.10	436.90	389.30
35	554.99	544.18	513.46	439.78	391.86
36	558.62	547.74	516.82	442.66	394.43
37	562.26	551.30	520.18	445.54	396.99
38	565.89	554.87	523.54	448.42	399.56
39	573.16	561.99	530.26	454.18	404.69
40	580.42	569.12	536.99	459.94	409.82
41	591.32	579.81	547.07	468.57	417.52
42	601.77	590.05	556.74	476.85	424.89
43	616.30	604.30	570.18	488.37	435.15
44	634.47	622.11	586.99	502.76	447.98
45	655.81	643.04	606.74	519.68	463.05
46	681.25	667.98	630.27	539.83	481.01
47	709.86	696.03	656.74	562.50	501.21
48	742.56	728.10	686.99	588.41	524.30
49	774.81	759.71	716.82	613.97	547.07
50	811.14	795.34	750.44	642.76	572.72
51	847.02	830.52	783.63	671.19	598.06
52	886.53	869.26	820.19	702.50	625.96
53	926.50	908.45	857.16	734.17	654.18
54	969.64	950.76	897.08	768.36	684.64
55	1012.79	993.06	937.00	802.55	715.10
56	1059.57	1038.93	980.28	839.62	748.13
57	1106.80	1085.24	1023.97	877.04	781.48
58	1157.21	1134.67	1070.61	916.99	817.08
59	1182.19	1159.17	1093.72	936.79	834.71
60	1232.60	1208.60	1140.36	976.73	870.31
61	1276.20	1251.35	1180.70	1011.28	901.09
62	1304.82	1279.40	1207.17	1033.95	921.30
63	1340.69	1314.58	1240.37	1062.39	946.63
64+	1362.48	1335.96	1260.54	1079.67	962.01

Employer Group Plans | 公司團體計劃

2019 Monthly Rates | *N. San Mateo County* | 北聖馬刁縣

January 1 - December 31, 2019 | 只適用於 1/1/19 – 12/31/19

- Each family member will be charged the premium for their age and rating region for their household.
- Only the first three of the oldest children under 21 in the family are charged; additional enrolled children will have no premium rate.
- All dependents age 15 and older are charged premiums based on their ages.

- 每位家庭成員的月費是根據年齡及居住地區計算。
- 只有前三名年齡最大的 21 歲以下子女會被計算入投保費用，額外的投保子女則免費。
- 所有15歲或以上的子女的月費是根據年齡計算。

	PLANS AVAILABLE OUTSIDE AND INSIDE COVERED CALIFORNIA (SHOP) 可通過或不通過投保加州市場選擇這些醫療計劃 (SHOP)				
	Platinum90 HMO 0/15 + Child Dental	Gold80 HMO 0/30 + Child Dental	Silver70 HMO 2000/45 + Child Dental	Bronze60 HMO 6300/75 + Child Dental	Bronze60 HDHP 6300/40% + Child Dental
AGE/年齡	**RATE/月費**	**RATE/月費**	**RATE/月費**	**RATE/月費**	**RATE/月費**
0-14	339.78	307.19	256.04	201.44	199.42
15	369.98	334.50	278.80	219.34	217.15
16	381.53	344.94	287.50	226.19	223.93
17	393.08	355.38	296.20	233.04	230.71
18	405.51	366.62	305.57	240.41	238.01
19	417.95	377.86	314.94	247.78	245.30
20	430.83	389.51	324.65	255.42	252.86
21	444.16	401.56	334.69	263.32	260.68
22	444.16	401.56	334.69	263.32	260.68
23	444.16	401.56	334.69	263.32	260.68
24	444.16	401.56	334.69	263.32	260.68
25	445.93	403.16	336.03	264.37	261.73
26	454.81	411.19	342.72	269.64	266.94
27	465.47	420.83	350.75	275.96	273.20
28	482.80	436.49	363.81	286.23	283.36
29	497.01	449.34	374.52	294.65	291.71
30	504.12	455.77	379.87	298.87	295.88
31	514.78	465.40	387.90	305.19	302.13
32	525.44	475.04	395.94	311.51	308.39
33	532.10	481.06	400.96	315.45	312.30
34	539.20	487.49	406.31	319.67	316.47
35	542.76	490.70	408.99	321.77	318.56
36	546.31	493.91	411.67	323.88	320.64
37	549.86	497.13	414.34	325.99	322.73
38	553.42	500.34	417.02	328.09	324.81
39	560.52	506.76	422.38	332.31	328.98
40	567.63	513.19	427.73	336.52	333.16
41	578.29	522.83	435.76	342.84	339.41
42	588.51	532.06	443.46	348.90	345.41
43	602.72	544.91	454.17	357.32	353.75
44	620.48	560.97	467.56	367.86	364.18
45	641.36	579.85	483.29	380.23	376.43
46	666.23	602.33	502.03	394.98	391.03
47	694.21	627.63	523.12	411.57	407.45
48	726.19	656.54	547.22	430.52	426.22
49	757.73	685.05	570.98	449.22	444.73
50	793.26	717.18	597.75	470.29	465.58
51	828.35	748.90	624.19	491.09	486.18
52	866.99	783.84	653.31	514.00	508.86
53	906.08	819.17	682.77	537.17	531.80
54	948.27	857.32	714.56	562.18	556.56
55	990.47	895.47	746.36	587.20	581.33
56	1036.21	936.83	780.83	614.32	608.18
57	1082.41	978.59	815.64	641.71	635.29
58	1131.71	1023.16	852.79	670.93	664.22
59	1156.14	1045.25	871.19	685.42	678.56
60	1205.44	1089.82	908.35	714.65	707.50
61	1248.08	1128.37	940.48	739.92	732.52
62	1276.06	1153.67	961.56	756.51	748.95
63	1311.15	1185.39	988.00	777.31	769.54
64+	1332.48	1204.68	1004.07	789.96	782.04